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Med	30). Name and add	ress of person	n who d	0	cause of de		23а) (Тур		470	5- 01	V1510^	v 5 f	1/23,	106 54/is	buy u
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Julius N. Freidlin January 16, 2006 5:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
July 30, 1 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1₩ 2□F 88 Yrs. 266-10-5633 1917 Florida Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits il Hygiene. other than "naturel", or fleme 23e or 28e-f ehow vent, the Mudical Examinat must be confilled at 1 Yes 2 No Maryland Montgomery Olney Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18121 Rolling Meadow Way 20832 U. S. A. within 72 hours after deeth 12. Was Decedent Ever in U.S. Amed Forces? 1 ≦ Yes 2 □ No Army If Yes, Give Aircore Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 Years Elementary/Secondary (0-12) Supervisor Bussiness Economist U. S. Government permit. Pages 1 and 2 should be filed w Depertment of Heelth end Mental Hygier Important: If Item 27 is marked other th eny Injury or other traumatic event, Ita page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Freidlin Sarah Dwoskin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Anna E. Freidlin - Wife</u> 18121 Rolling Meadow Way, Olney, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/17/2006 Judean Mem. Gardens Olney, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Reveal Direction, Inc. Donald (1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Bradycerdia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day 5 Other (specify) P.0. ed by the deteched f 9 Unknown 9 Unknown cete hes been signed I page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No After this certification funeral director, r or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient Medical Certification; To 1 ☐ Yes 2**X** No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending s efter death. investigation м 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e To the Funerel Completely filled in Hospitaf 11 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauce(e) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056063 30 $M \cdot D$. 30. Name and address of prison who co Kanwaljit K. Nagi leted cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD 20910 32/Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 20 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Malvina FRANKEL **Physician** January 18, 2006 9:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Brighton Gardens Nursing Home Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖔 F Yrs. 89 Director 127-03-6827 July 13, 1916 New York Usual Residence of Decedent the Maryland 10d. Inside City Limits 10s. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exercicer must be notified at 1 ☐ Yes 2 💢 No Maryland Montgomery Rockville Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 2015 Dundee Road 20850 Items 23e United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Importent: If item 27 Is marked other th any fijury or other traumatic event, the angle. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rudolph H. Grossman Rose Appel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elissa Scheinberg, Daughter 2015 Dundee Road, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 01/20706 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Eternal Light Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Boynton Beach, FL 21. Signatura | Funeral 5 vice kicensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinson's Disease /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease
Due to (or at a consequence f): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit Atrial Fibrillation and Due to (or as a consequence of): P.O. Box 68760. attending physicien for use as the buria Physician/Medical _Osteoporosis IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2√☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2X No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: After 5 Pending investigation 1 XNatural 1 Tyes 2 No М death. 2 Accident after death in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30132 January 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Ghosh, M.D., 14804 Physicians Lane #221, Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 20 2006 Registrar

		1- For State of Maryland	-	artment o				giene Reg. No.	06	03505
2		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	siciar edica	Florence K. Ford					January		2006	2:20 P M
	mine	4a. Facility Name (If not institution, give street and number)		4b. City, Tow	vn, or Lo	ocation of De	ath	4c. Cour	nty of Death	
		Wilson Health Care Center				hersbu	0	Mon	tgome	ry
Fune Direct		5. Social Security Number 203-05-4110 6. Sex 1 □ M 2 ▼ F 87 87	birthday) Yrs.	If Under 1 Y Months Da		Hours Mi		v. Year)	9. Birth Cou PA	place (State or Foreign ntry)
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death with the Maryland rms 23a or 28a-f show	Funeral Director	122 Lamont Lane		10f. Zip Co	® 878					*
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Vica South the Ment of the Arrive	5					Helen	Butsavi	.ch		
DESILITIOTE, MISTYIETIGE 2.12.10-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other then "neturel", or Items 23a or 28a-1 show any injury or other treumstic event. It is Marcial Examine must be refulled.				-			Rural Route Numbe			
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allimore, mit. Pages 1 av partment of Hea portent: If Item	5	1X Burial 2 ☐ Cremation 3 ☐ Removal from State	etery, crer	matory or other	r place)	Jan	uary 20	20c. Locatio		
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Physici. /Medic Examin cieu and pore executed	eal ier	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue ul).	ere Tagar	kr	lare	cel			Opset and Death FULLES
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olitel of urs all pred in	3									
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has commissed filled in but he funeral director, nace 2.	odical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, deati and/or in	n occurred at ti vestigation, in	ne time, my opir	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)
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3		20 Name and address of carron who completed across of death (the of	a) Trees	Print)	01	D11	55// 2	1 - A	ary	, = / = = +
		30. Name and address of person who completed cause of death (Item 23) 14 ROBERT BIRSCHBACH,	ULL	3	41-	T4181	ESBURG	MIK	20	847
Door	State	31. Date tiled (Month, Day, Year) 32. Registrar's Signature	L.	solv.		/		, , , , ,		
neg	istrai	ALIM OF TOOL TOWN	1							

JC 06-00691 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1,23a,27,28a-f, perME, (852,2/16/06 TT
Unpend State of Maryland / Department of Health and Mental Hygiene Daniel Patrick Fanning 1 - For State Registrar 03506 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19:22 P ^M January 27, 2006 Daniel Patrick Fanning /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belair Harford Upper Cheasapeake Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 213-76-6903 48 July 9,1957 <u>West Virginia</u> Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r then "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 3016 West Franklinville Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 12 should be filed within 7 h and Mentel Hygiene.
7 Ie marked other then "r Heavy Duty Mechanic Elementary/Secondary (0-12) College (1-4or 5+) Repair Shop 12 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Patrick Fanning, Sr. Juanita Kathryn Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Heelth ant: if item 27 I ury or other tra Tammy Fanning/Wife 3016 West Franklinville Road, Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition
1 □ Burial 2496 remation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) 2-1-06 Hilltop Serv. Corp. Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Asphyxia due to inhalation of exhaust fumes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b autopsy performed2 2 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 1 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 28b. Time of Fnd 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 No investigation Jan. 27,2006 6:30 P 2 Accident Subject inhaled toxic fumes 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3016 Franklinville Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Residence Joppa, MD Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABIUCCAH 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, 27, 29a, perME, 9850,677/06 TT State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MATTHEW DAVID FRITZ JAN 26 2006 9:44 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PAX RIVER - NAVAL AIR STATION LEXINGTON PARK ST. MARY'S If Under 1 Year If Under 24 Hrs. 6. Sex 1 → M 2 ☐ F 8. Date of Birth (Month, Day, Year) JUL 7 19 Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs Director 406-17-6299 28 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show eny Injury or other traumatic event, the Madical Exeminar process. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo Maryland St. Mary's Patuxent River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1452 Buse Rd. Rm #135 20670 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∑Yes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 11. Marital Status 1X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Patrol Man U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Edward Fritz Mary Ann Meunier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Fritz / Father 5316 Rippling Brook Way Carmel IN 46033 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 2, 2006 4 ☐ Donation 5 ☐ Other (Specify) Hamilton Memorial Park Noblesville, IN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. nichael Keun Harline P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Drowning /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b/ Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ icate has been sig ; page 2 should b 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ፟ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1X Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1X Yes 2 No ို 2 ER/Outpatient 3 DOA this is 28b. Time of unk 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 5 Pending investigation After Injury 1 Natural within 24 hours after death. To the Funerel Director: A 1 Yes 2√2 No 2 Accident 3 Suicide JAN 26 2006 FOUND IN SWIMMING POOL A the 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide LEXINGTON PARK MD PAX RIVER NAS GYMNASIUM 29a. Certifie 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely one) To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D-0055313 EXAMINER ct down (Item 23a) (Type, Print) ARMED FORCES MEDICAL 30. Name and a dress of person who comple 1413 RESEARCH BLVD ROCKVILLE MD 20850 EDWARD A. REEDY CDR MC USN

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0 1 2006

Colo

egistrar's Signature

32

	_1	For State Registrar				t of Health and N e of Death	Reg	2006 I. No.	0 3 5 0 8
Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Las Michael W. Grabi Facility Name (If not institution, give	11		4b. City,	Town, or Location of Death	2. Date of Death Month January	Day Year 19, 2006 4c. County of Dea	8:55 A
Funeral Director		University of Mary 5. Social Security Number 215-54-6749 Usual Residence of Decedent	rland Medica ox 7. Age (1 2M 2 F 55	al System n yrs. last birthday Yrs.	ns y) If Unde Months	Baltimore 11 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,)	^{9. Bit} 1950 Was	rthplace (State or Forei ountry) hington, DC
f show		10a. State 10b. County Maryland Anne Ar		Oc. City, Town or L	Location Riva				10d. Inside City Limi
e notili	Olrec	10e. Street and Number			10f. Zij	Code	10	g. Citizen of What C	ountry?
Depertment of Health and Mental Hygiene. Important: or Items 23s or 28s-f show Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, Its Medical Exeminar must be notified at once.	by Fur	2774 Cedar Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S. 13	3. Was Dece If Yes, spe 1 \(\text{Yes}	21140 dent of Hispanic Origin? (Story Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	USA 14. Race - Am Black, Wh Specify:	
natura dical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	cedent's Usu ve kind of w	al Occupation ork done during most of work		6b. Kind of Busines	s/industry
than re Ma	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 2 yrs.		er/Ope			Audio-Vid	eo
ental Hygik Kad other Ic svsnt, II	To Be Co	17. Father's Name (First, Middle, Last) Wilson Henry	-	OWIL	or / ope	18. Mother's Nan	ne (First, Middle, M a Harbin	aiden Sumame)	
s mari		19a. Informant's Name/Relationship (Гуре, Print)	19b. Ma	iling Addres	s (Street and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
or other tra		Connie C. Grabill 20a. Method of Disposition 1 Burial 2 ACremation 3	Removal from State	20b. Place of Dis cemetery, ci	position (Na rematory or	other place)	Date 2	Oc. Location - City of	or Town, State
Depertmen Important: sny injury once.		4 Donation 5 Other (Specification of Funeral Service Licer		Kalas (22. Name a	nd Address of Facility Geo Solomons Isla	orge P. K		ral Home
hysician and parisistransit parisistransit	al Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Choland Due to (or as a control of the control o	gio Carci consequence of): nonsequence of):					Interval Betweer Onset and Deatl 1 years
ned by the attending physical detached for use as the land	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□ Unknown	Fetel death	3 □Ectopic 5 □ Other (9			23d. Date of o Month	delivery Day Year
s been signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying	cause given in Part I.	1		to the cause of deat Probably 4 Unk
has 362	Completed						24a. Was ad autops perform 1 \(\text{Yes} \) 2	y prior t ned? death	autopsy findings ava o completion of caus ? es 2 \sumbox No
this certificeteral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	t 2 ER/Outpa	tions 201	Other	ath (Check only on	e) ince 6 □Other (S	necify)
After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time	e of	28c. Injury at Work? 1 Yes 2 No		w injury occurred	,
after de Directo in by th	Certification:	3 Suicide 6 Could not to determined	building, etc.				City or Town	n, State)	Rural Route Number
s nospital 124 hours a s Funeral letely filled	Medical	29a. Certifier 1 X Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/o	eath occurre or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
within 2 To the comple	Me	29b. Signature and title of certifier			2	9c. License number	2	9d. Date signed (M	onth, Day, Year)
		1 CM				15121		1/19/0	le

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GERALD **Physician** CELES 10.45pm D1/Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT THOMAS MORE NURSING HOME Hyattsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 8. (Month, Day, Yeer) 6. Sex 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Yrs. Director May 29,1933 Fairmont, NC 237-56-8352 Usual Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural, or items 23e or 28a-f shov traumstic event, the Medical Examinar must be notified at ★ Yes 2 No Maryland Prince George's Directo Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 USA 4922 LaSalle Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filad within 72 hours aftar all Hygiane. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: δ Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Linen Handler Private Industry 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mantal Hiant: If Item 27 is marked oth Be ပ Lizzie Inman Ken Gerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) other 1 Nicola Gerald/daughter 610 Buchanan St., N.E. Wash., DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of important: if any injury or once. Fort Lincoln Cemetery 1/27/06 Brentwood, Md. 22. Name and Address of Fecility
Frazier's Funeral Home, Inc. 21. Signature of Fundal Service Licensee 1401453 B89 R.I. Ave., N.W. Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. SEPSIS Examiner Due to (or es e consequence of): Physician/Medical Examiner law requiras that tha death cartificata ba executed attanding physician and for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MULTIPLE ORGAN FAILURE þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed DIABETES MELLITUS END STAGE RENAL DISEASE 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Box 68760, Division of Vital Records, P.O.

this Diractor: After thi daath. filled in by To the Hospital
within 24 hours a
To the Funeral C

State Registrar

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. (Check only 29b. Signature and little of certifier

5 Pending

investigation

6 Could not be determined

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

1 Natural

Certification:

Medical

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name end address of person who completed dause of death (Item 23e) (Type, Print)

3503 Perry Street Mt. Rainer, Maryland Raman Tuli, MD

28e. Dete of Injury (Month, Dey Year)

31. Date filed (Month, Day, Year) JAN 24 2006 Registrer's Signature K April

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) JAN 2 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL WALLEYNE M.D. 6001 LANDOVER ROAD # 8 CHEVERLY, MARYLAND 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2006 Month **Physician** 22, Louise Ernestine Gleason Jan. 1:15 p.m /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maria Health Care Center Baltimore Baltimore If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 K F Yrs. Feb. 1, Director 218-56-9932 90 1915 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo 28a-f Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code ò Herns 23a 6401 North Charles Street 21212 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 € No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Music Teacher Catholic Schools other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be nant of Health end Mentel Louis B. Gleason Bridget E. Shea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Relationship (Type, Print) Department of Health e Important: if item 27 is eny injury or other tra once. Mary Donohue, SND/ Superior 305 Cable Street, Baltimore, Maryland 21210 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 26, Jan. 1 Removal from State 2 □ Cremation 3 □ Removal from State 2006 4 Donation 5 Dother (Specify) Olivet Cemetery Washington, DC 21. Signature of Funeral Service Licensee Francis Addess Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 com 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 5 Days Examiner Due to (or es a consequence ol): Physician/Medical Examiner Multiple Cerebral Infarctions 2 Years nding physician end use as the bunel-transit Attending Physician: The law requires that the daath cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): signed by the at d be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed by cata has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 TYPE ZZ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No this funerel 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? After s after dea. 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide fillad in t 0 To the Hospital o within 24 hours af To the Funeral DI Completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D01373 January 24, 2006 anno MUNK

Registrar

State

7505 Osler Drive, #212, Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2006

M.D.

32 Registrer's Signature

Francis X Carmody,

25

31. Date filed (Month, Day, Year)

		•	For State Registrar	State of N	Maryland / Dep Ce	artment of H			iene No. 06	03512
	Dis		1. Decedent's Name (First, Mide	ile, Last)				2. Date of Deat Month	h Day Yea	3. Time of Death
₹.	Physici /Medio		Eleanor	Garetter	Grimm			January		
}	Examin		4a. Facility Name (If not instituti		r)	4b. City, Town, or		h	4c. County of De	
			4402 Sanfor			Belcar If Under 1 Year	mp If Under 24 Hrs	8. Date of Birth	Harfo	
	Funeral Director		5. Social Security Number 218-38-7535	6. Sex 1 □ M 2 □ XF	Age (In yrs. last birthday 76 Yrs.	Months Days	Hours Min.	(Month, Day,	0,1929 1	irthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. Count	ly	10c. City, Town or I	ocation				10d. Inside City Limits
	Mary -f sho	টু	MD Ha	rford	Belcar	np				1 ☐ Yes 2 XNo
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	th with		4402 Sanfo	rd Court		210	17		USA	
	ema erra	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wi	nerican Indian,
98	or it	J. F.	1 Never Married 2 Ma	arried 1 □ Yes 2 X	Ž No	1 ☐ Yes 2 ☐XNo	Specify:	, ,	Specify:	White
00	ural',	d by	3 ☐ Widowed 4 🏋 Divorce	Year or Dates						
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event. If a Madical Examinat must be notified at	Completed	(Specify only high	ent's Education lest grade completed)	16a. Dec (Giv	edent's Usual Occup e <i>kind of work done d</i> DO NOT use retired	ation during most of wo	rking	16b. Kind of Busines	ss/industry
12	filed withi Hyglene. other than ent. It e M	E C	Elementary/Secondary (0-12)) College (1-4o		Vaitress	7.		Restau	rant
	filed Hygld other ent.	0	17. Father's Name (First, Middle	e, Last)			18. Mother's Na	me (First, Middle, I	Maiden Surname)	
<u>a</u>	ould be Mental arked o	To B	Quincy And	rew Swann			Ruth N	largaret	Welch	
Maryland	2 should I and Ment is marked		19a. Informant's Name/Relation				and Number or R	ural Route Number	, City or Town, State	
	1 and 2 Health a tem 27 is		Lorraine Wi	lliams/Dau	Contract of the Contract of th			Belcamp	,MD 210	L7
ore	of He of Her		20a. Method of Disposition ↑ □ Burial 2 □ Cremation	2 Demouslifeen Ste	20b. Place of Disp cemetery, cri	osition (Name of ematory or other place	:0)	Date	20c. Location - City	or Town, State
Ĕ	Pages ment of P ant: If ite ury or o		'4 □Donation 5 □Other		Christ	Church		25/06	Wayside	,Maryland
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service	5,70	M00945	AREHART	ss of Facility -ECHOLS	FUNERA	L HOME,	P.A.
			23a. Part1. Enter the disease,	or complications that caus st only one cause on each	ed the death. Do not e	nter the mode of dyin	A 30/, L g, such as cardia	c or respiratory arr	, MD . 206	Approximate Interval Between
1	Physician	2	Immediate Cause (Final disease or condition	or only one sales on sales.	Small	1 Cell	lun	9 Can	cer	Onset and Death
1	/Medical		resulting in death)	aDue to (or a	as a consequence of):		1]		187110111
8	Examiner		Sequentially list conditions	b						
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	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
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9 ×	leath certifica attending ph	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				22d Date of a	dalikan.
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	Day Year
o.	that the do	yslo	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown						
<u>α</u>	res that thigned by be detac		Part II. Dther significant condi	tions contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires n sign	d by						1 2 Y	9s 2□No 3□	Probably 4 Unknown
ecords,	w requir s been s should	Completed						24a. Was a		autopsy findings available
α	9 4 9	mo mo						autops perfori	med? prior t death	
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medic	cal			26. Place of De	ath (Check only or		65 2010
\geq	d is	0 B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpa	itient 2 ER/Outpatie	ent 3 DOA Oth			ence 6 Other (Sp	pecify)
Jor		n: T	27. Manner of Death	28a. Date of In (Month, I	njury 28b. Time Day Year) Injury	of 28c. Injury	y at k?	28d. Describe ho	ow injury occurred	
Division	Attending Ph r death. sctor: After th by the funeral	Certification;	2 - Modidoni	stigation	, , , ,		Yes 2 □ No			
Νį	or Attendation after death Director:	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 286. Place of I	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
Q	Ital or irs afte ral Dir led in	Cer		Ep.						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certify (Check only one)	ying Physician: To the be- al Examiner: On the basis and manner	of examination and/or	ith occurred at the tin nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the c urred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certif	ier		29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
)			> Suara	u las		D5	7702		1/21/06	
0	7 1		30. Name and address of person	on who completed cause o	f death (Item 23a) (Type	p, Print)	N	Part		KAN 21423
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	Sta Registi		31. Date filed (Month, Day, Yea	2 5 2006 A	strar's Signature	book				

			For State Registrar		5	State of M	Maryland / i	Departme <i>Certifica</i>				ientai H	ygien Reg. N	. U U D		3513
			1. Decedent's Nam	, ,							-	2. Date of I		ay Ye	221	3. Time of Death
	Physicia /Medic		Barba	ra L.	. (Grimes						JAN	23	*		11:15 P
	Examin		4a. Facility Name (er)		ty, Town, or		of Death		4	c. County of [
		*	5. Social Security	A MEDIC	CAL C.		Age (In yrs. last bi		APLATA der 1 Year	A If Under	24 Hrs.	8. Date of 8	lieth	CHARL		ace (State or Foreigr
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			Usual Residence	of Decedent		<u> </u>		1								
arylan	how	_	MD	10b. County			10c. City, Tow		. 1						10	od. Inside City Limits ↑▼ Yes 2 No
he M	Ba-f	ecto			res		Inc	lian H					10= 0	National ad NA/Inc.		
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r deal	ems er a	ner	11. Marital Status		12.	Armed Force	nt Ever in U.S. s?	13. Was De	cedent of H	ispanic Ori in, Mexicar	igin? (Spi	ecify Yes or I Rican, etc.)	No-	14. Race - A Black, V		
Z I Z I 3-UU36 od within 72 hours afte	al, or li Examin	ğ	1 □ Never Mar 3 Widowed	ried 2□ Marı 4 □ Divorced		Yes 2[If Yes, Give Year or Date:	□ No s:		2 XNo	Specify:				Specify:		White
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INVISION OF VICENTRECORDS, P.O. BOX 68/6U, Or Attending Physician: The law requires that the death certificate be executed $\mathbf{W} \geq \mathbf{E}$	terstiff. terrificate has been signed by the attending physician and bear stored for use as the burial-transit by the the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	To Be Completed by Physician/Medical E	23a. Part1. Enter shock, or he Immediate Cause disease or condition resulting in death. Sequentially list of any, leading to it cause. Enter Und Cause (Disease ot hat initiated even resulting in death) IF FEMALE: 23b. Was decede in the past of 1 yes 2 yes yellow and yellow	the disease, or art failure. List (Final on on ditions, mmediate erlying rinjury is Last the first of the fir	a	Due to (or Lif yes, outcor 1 Live birth 4 Pregnant 9 Unknowr buting to deatt (Month, 28a. Place of building, ian: To the best: On the basis	atient 2 FR/O njury 28b. Injury - At home, field. (Specify)	AREHAPO not enter the not ente	and Addres ART – EBOX node dyin Coperation of the Coperation of th	en in Part I 26. Place er: 4 \(\text{NL} \) Yes 2 \(\text{NL} \)	S F LA cardiac e of Death	23e. Die 24a. Wie pe 1 Yes and due to the property of the percent of the percen	I H Arrest. I tobacco Yes as an topsy from topsy fr	23d. Date or Month 2 Use contribut 2 No 3 (24b. Wer prior death of the contribut of the contribution of the c	A. 6 f delive te to th Probi e autor r to con th? Specify or Rura.	Approximate Interval Between Onset and Death Onset and Onset and Onset and Onset and Onset Indiana Ons

State

Registrar

SONG C. CHON MD CENNA MEDICAL CENTER 7C POST OFFICE RD. WALDORF, MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 5 2006

31. Date filed (Month, Day, Year)

		1 - For State Registrar	State of Maryl	and / Depa		lealth and	Mental Hyg		006	03514
Physic /Med		Decedent's Name (First, Middle, Last, Ralph Abdo George					2. Date of Dea Month January 2	Day	Year 5	3. Time of Death 1:43 P M
Exami		4a. Facility Name (If not institution, give Holy Cross Hospital			Silver S			Monte	nty of Death	
Funeral Director		5. Social Security Number 6. Se 176–20–8952 Usual Residence of Decedent	7. Age (In)	79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year)		place (State or Foreign ntry) nsylvania
death with the Maryland me 23s or 28s-f ehow I must be notified at	Director	10a. State 10b. County Maryland Montgomery		City, Town or Lo	r Spring			10a Citizon	of What Cou	10d. Inside City Limits 1 ☐ Yes 2★☐ No
th with t	al Dir	10e. Street and Number 2340 Montgomery Street			10f. Zip Code 20910			USZ		nuy:
	by Funeral	11. Marital Status 1 ☐ Never Married 2⊠ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 194		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		specify Yes or No- to Rican, etc.)		Race - Amen Black, White, c <i>if</i> White	
within 72 hours after ane. then "naturel", or Ite	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	rking		f Business/Ir	·
id be filed wental Hygiar Ked other the cevent, In	To Be Cor	17. Father's Name (First, Middle, Last) Abdo George	4	Mi	litary Offi	18. Mother's Na	me (First, Middle,	Armed	Forces	
2 should be to and Mental I	F	19a. Informant's Name/Relationship (7)	rpe, Print)		ng Address (Street	and Number or Ri	ural Route Numbe			o Code)
Peges 1 and import of Heelth tent: If item 27 jury or other tr		Natalia George/Wife 20a. Method of Disposition 1 Darrial 2 Geremation 3 DF		b. Place of Dispo	Montgomery osition (Name of matory or other place an Crematory	ce) Tanı	Silver Spri Date Jary 29,	-	20910 on - City or T	own, State
permit. Pe Departmen importent eny Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		4	Namered Address	Solfies Fu		Inc	7	Jirginia Ol
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Coronary Ar Due to (or as a con	tery Disea		ng, such as cardia	c or respiratory ari	rest,		Approximate Interval Between Onset and Death Years
eath certificate be executed ettending physicien and for use as the burial-trensit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con							
the d y the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3[□Ectopic pregnanc	ý		23d.	Date of deliv Month	ery Day Year
w requires that the de been signed by the e should be detached i	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	underlying cause giv	ven in Part I.				he cause of death? bably 4XUnknown
The law ate has b page 2 si	Completed	74. 4 - 7					24a. Was a autop perfor 1 Yes	sy med?	lb. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	ot 308 DOA Ott	100	ath <i>(Check only or</i> Home 5 ☐ Resid		Other (Spec	6.1
To the Hospitel or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		27. Manner of Death 1 Salural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		of 28c. Injur	y at	28d. Describe h			(1)
Itef or Atterned and Directors	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	ecify)			City or Tow	m, State)		al Route Number,
the Hosp nin 24 hou the Fune upletely file	Medical	(Check only 2 Medical Exemi	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, deal nination and/or in	vestigation, in my o	opinion, death occ	urred at the time, o	date and plac	ce, and due t	o the cause(s)
20+1	2	29b. Signature and title of certifier	PAS .		29c. Licens D520				gned (Month, wary 21,	
		30. Name and address of person who c Julia Krivy, M.D 10	ompleted cause of death 313 Georgia Av	enue, Suit	te 306, Sil	ver Spring,	, MD 20902			
Si Regis	tate trar	31. Date filed (Month, Day, Year) JAN 2 4 20	32, Registrar's S	ignature	out ?					

		1- For Amend Item 2	25 per ME ,	G857	,0772g	ortment of 706dhb tificate	of Health of Deat	and M	/lental	Hygie Reg	ene () (16	03515
Physic	ian	1. Decedent's Name (First, Middle, La.	st)						Mon	of Death th	Day	Year	3. Time of Death
/Medi		ULEN GAI	10/11			41. O'r. T-		(D-++	Jan	uary		006	0700 "
Exami	ner	4a. Facility Name (If not institution, giv	1 11) 1	- 1		on, or Location				4c. County	el bo	+
Funeral		5. Social Security Number 6. S		ge (In yrs.	. last birthday)	If Under 1 Y	ear If Und	er 24 Hrs.	8. Date	of Birth		9. Birthp	lace (State or Foreign
Director		218-34-8647	© M 2□ F	67	Yrs.	Months D	ays Hours	s Min.	MAR	of Birth th. Day, Y	1938	MARY	ŽLAND
and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
4 within 72 hours after death with the Maryland yiene, 'natural', or Iteme 23a or 28a-f show tre Medical Examirar must be notitied at	jo	MD TAL	вот		EAS'								1 □ Yes 2 No
r 28a	Director	10e. Street and Number				10f. Zip Co	de			100	g. Citizen of N	What Coun	itry?
23a o		9648 LEEDS LAND	ING CIRCL	E			21601					USA	
teme Fr. m	by Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13.	Was Decedent If Yes, specify	ol Hispanic (Cuban, Mexic	Origin? (Sp can, Puerto	ecify Yes Rican, e	or No- tc.)		ce - Americ	
0 1	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates			1 ☐ Yes 2 🛣	No Speci	ify:			Specif	y: WHI	TTE
CalE	ed	15. Decedent's Ed	ducation		16a. Deced	dent's Usual O	ccupation			16	6b. Kind of B		
Medi	piet	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of work d DO NOT use re	one during m etired)	ost of work	king				
4	Completed	12	0	,	F	ARMER					AGRIC		RE
COVE	Be	17. Father's Name (First, Middle, Last, OLEN W. GAMBRIL					18. Mo			Middle, Ma	aiden Suman CELL	ne)	
reumatic ev	To	19a. Informant's Name/Relationship (Туре, Print)		19b. Mailir	ng Address (St	reet and Num	nber or Rui	rai Route	Number, (City or Town,	State, Zip	Code)
if item 27 is marked other or other treumatic event,		NANCY S. GAMBRIL	L/WIFE		-	8 LEEDS			-				
or of		20a. Method of Disposition 1 Buriai 2 Cremation 3	Removal from State	9	Place of Dispo cemetery, crer	natory or other	r place)	1	Date		c. Location		
ular.		4 Donation 5 Other (Specifical Signature of Funeral Service Licer		WO	ODLAWN	MEMORI 2. Name and A			28/20	006	EASTON	I, MAI	RYLAND
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cian		Immediate Cause (Final disease or condition			ccome	SELW	DA INFE	ECTIC	M				Onset and Death
dical niner		resulting in death)	Due to (or a				D MIL	, 10					
ner	<u></u>	Sequentially list conditions,	b. PEL	SIC		4 TOM.	1						
nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	C-PA		ENAL I	SISCA	SE			1	/	
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the bur	dical		d						1	, ,	00	AL EXAMINE	
	Med	IF FEMALE:							-	Ý	EN BY MEDIC		
or use	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fet	al death 3	Ectopic pregn				TON APPRO	23d. Da	ite ol delive onth	ory Day Year
be detached for use as	ysic	1 Yes 2 No	4□Pregnant 9□Unknown	at time of	death 5∟	Other (specif	y)		CERTIFICA	lio.			,
detac	/Ph	Part II. Other significent conditions	ontributing to death	but not re	sulting in the u	nderlying caus	e given in Pa		1			tribute to th	ne cause of death?
ed be	Q P	ANEMIA								1 🗆 Yes	2 🗆 No	3 🗆 Prob	ably 4 Naknown
plnods	Completed	DIABETS	ES MEI	LIT	us				24a	. Was an	24b.	Were auto	psy lindings available
page 2	mo m						-		10	autopsy performe Yes 2	ed?	prior to cor death? 1 Yes	mpletion of cause of
i .	BeC	25. Was case referred to medical					26. Pla	ace of Deat	4			7 - 103	
I director, p	2	examiner?	Hospital:	tient 2	☐ ER/Outpatier	nt 3 DOA	Other: 4 🗆	Nursing Ho	ome 5[Residen	ce 6 ⊟Oth	ner (Specify	y)
funeral director,		27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D		28b. Time o Injury		Injury at Work?		28d. Des	scribe how	r injury occur	red	
the	cat	2 Accident investigatio 3 Suicide 6 Could not b	e One Diese et l	piune - At h	home form et	M factors of	1 Yes 2	□NO	281 Loc	ation (Stre	et and Numl	her or Rum	I Route Number,
d in by	Certification:	4 Homicide determined	building,	etc. (Spec	rify)	eei, iactory, or	nce		City	or Town,	State)	Jer or Hura	i noble Mulliper,
completely filled in by	edicai C	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nysician: To the bes miner: On the basis and manner:	of examin	nowledge, death nation and/or in	h occurred at to vestigation, in	he time, date my opinion, o	and place, death occur	, and due rred at the	to the cau time, dat	ise(s) and m e and place,	anner as st and due to	tated. the cause(s)
To the Funeral i	Me	29b. Signature and title of certifier				29c. Li	cense numbe	91		290	d. Date signe	ed (Month,	Day, Year)
		D. Chiaufin	mi K	1)		D	432,	61		(01/2/	6/20	06
_		30. Name and address of person who	completed cause of	death (Ite	em 23a) (Type,			- '			Jac	1000	
_		DR. OBAY	ML 21	95	S WAS	HING'	TON S	TR 960	T, E	ASTI	M M	0 21	601
St	ate	31. Date filed ANPth 2Day Y2006	32. Regis	trar's Sign	nature								

			1 - For Stata Registrar	ate of Maryland		rtment of H			iene og. No.	06	03516
	Physici	20	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medic	_	ELLEN K. GREENE					January	17	2006	3:30 P M
A.	Examin	er	4a. Facility Name (If not institution, give street				Location of Death			nty of Death	
	Funeral		Manor Care of Bethes 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	Bethesd: If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		tgomer 9. Birthr	place (State or Foreign
	Director		124-24-6579 ^{1□ M}	² Sx ^F 7:	2 Yrs.	Months Days	Hours Min.	Jan. 25,		Gern	**
	pg &		Usual Residence of Decedent 10a, State 10b. County	10c City	, Town or Loc	ration					Od. Inside City Limits
	daryle f eho	ō									1 □Yes 2 🛣 No
	28a-	Director	MD Montgome 10e. Street and Number	ту ве	thesda	10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
	h with		5514 Charles Street			20814		τ	nited	State	:S
	ema ?	Funerai		Vas Decedent Ever in U.S	6. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		lace - Americ	
30	s afte	by F.	If	☐Yes 2 No Yes, Give		☐ Yes 2√2 No	Specify:			cify: Whi	
3	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Heme 23e or 28e-f ehow thit, fra Medical Examinar must be notified at		15. Decedent's Education	ear or Dates:	16a. Deced	ent's Usual Occup	ation		16b. Kind of	Business/In	dustry
212	nin 72	piet	(Specify only highest grade con		(Give I lite. D	kind of work done of NOT use retired	during most of work ()	king			
N	filed with Hygiene other the	Completed	2-011-011-01-01-01-01-01-01-01-01-01-01-0	5+	Teach	er					Education
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "natural", or Hema 23a or 28a-f show event, Ita Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam			ame)	
2	d Mer narke natic	2	Leo Kalberman 19a. Informant's Name/Relationship (Type, F	Daines	10h Mailia	- Addrson (Stroot	Melanie and Number or Rur	Greenba		m State Zir	Code
Maryiand 21215-0036	ith an 27 is 1		Neil R. Greene, Husb				Street,			20814	
ē,	f Hear Item		20a. Method of Disposition	20b. Pl		sition (Name of natory or other place				n - City or To	
Ē	Page nent o		ttal 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	vai ii oiii State		m. Garden	1	2-2006	lney,	MD	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Julury or, other treumatic event, ORGS.		21. Signature of Funeral Service Licensee	00				es-Rinal	di Fu	neral	Home, Inc.
11	20 E E 3		P Clay h	Jumell			lampshire			pring	MD 20904 Approximate
3760,	Physician // Medical Examiner purision on physician phys	dicai Examiner	23a. Part1. Enter the disease, or combication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it may be a failed by the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Cerebrov Due to (or as a consequ Due to (or as a consequ Due to (or as a consequ	ascula ence of): ence of						Interval Between Onset and Death Years
O. BOX 6	that the death certificate be executed ed by the attending physicien end detached for use as the burial-transit	Physician/Med	in the past 12 months?	yes, outcome of pregnan Live birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
r.	es that igned b	by Pt	Part II. Other significant conditions contribu	iting to death but not resu	tting in the un	iderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?
ğ	law requires as been sign 2 should be		Depression					1 🗆 Y	es 2. TageNo	3 ☐ Prol	bably 4 ∐Unknown
Vital Records,	e faw r has be ge 2 sh	Completed						24a. Was a autop:	sy	prior to co	opsy findings available impletion of cause of
E	The este							perfor		death?	2□ No
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospi	tal:	EB/Outpation	Oth	er: 4 X Nursing Ho			Other (Case	6.1
lo no	ding After fune	tion: To			28b. Time of Injury	28c. Injur Wor	y at	28d. Describe h			197
DIVISION		Certification;	a Cloud and be -	Be. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Run	al Route Number,
	To the Hospitel or Within 24 hours after To the Funeral Dircompletely filled in	edicai	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, o	ause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
	To the To the complet	Ž	29b. Signature and title of certifier			29c. Licens	e number			ned (Month,	
ļ	15		nent U Do	user MD		D 3	7840		Januar	y 19,	2006
			30. Name and address of person who comple				. 100 P	4b - 1	MD 0	0017	
	Sta	ite	Brent A. Berger, MD 31. Date filed (Month, Day, Year)	10215 Fernwo			± 100, Be	rnesda,	<u>гш 2</u>	0817	
100	Registi		JAN 20 2006	Brance S.	dos.						

		1	For State Registrar	State	of Maryland		irtment of H <i>tificate of I</i>		Mental Hygie	2000	5 0	3517
_			Decedent's Name (First, Middle	. Last)					2. Date of Death	. 110.		3. Time of Death
	Physicia	an		,					Month		rear	o con M
	/Medic		CHARLOTTE P. GI 4a. Facility Name (If not institution		, mbos)		4h City Town or	Location of Death	January	4c. County of	006	3:40P M
	Examin	er		give street and m	uniber)				1_			
			Hebrew Home	0.0	7 100 (10	4 6 : 46 -41	Rockvill If Under 1 Year	e If Under 24 Hrs.		Montgon		(Chata as Famina
	Funeral		5. Social Security Number 137–20–5924	6. Sex 1 ☐ M 2XX F	7. Age (In yrs. In 78		Months Days	Hours Min.	8. Date of Birth (Month, Day, Y June 15	1927 I	Countr	ce (State or Foreign
	Director	-	Usual Residence of Decedent						June 15	1927	alle	rson, NJ_
	and **		10a. State 10b. County		10c. City	, Town or Lo	cation				100	3. Inside City Limits
	Maryl sho	5	MD M		D	1						1 TyYes 2 □ No
	he N	Director	MD Mon:	tgomery	Koc	ckvill	e 10f. Zip Code		100	. Citizen of Wi	nat Countr	w2
	with De r				١.٥							
	s 23g	Funeral	6121 Montrose				20852			nited S	· America	
	er de	nu	11. Marital Status	Armed F		5.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)		, White, et	
36	or or	by F	1 Never Married 2 Marr 3 XWidowed 4 Divorced	ed 1 Yes If Yes, G Year or			1 ☐ Yes 2 ◯XNo	Specify:		Specify:	Whi	te
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or Items 23e or 28e-f show event, I're Medical Exait are must be notified at		15. Deceden		Dates.	16a Docor	dent's Usual Occup	ation	16	ib. Kind of Bus	iness/Indu	reto,
ģ	"na"	Completed	(Specify only highes	t grade completed		(Give	kind of work done of the contract of the contr	durina most of wo	rking	o. King of Bus	111033711102	.su y
2	within	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)			-7		Account	ina	
7	Hygie Hygie other		17. Father's Name (First, Middle,	(act)		Bookk	eeper	18 Mother's Nar	me (First, Middle, Ma			
ŭ	be f d of	Be	Joseph Press						chwartzbei		,	
Š	should nd Men marke umatic	ို		oin (Tour Brins)		10h Mailie	- Address /Ctract		ıral Route Number, (State Zin (Code)
Maryland	0 4 4 5	8 7	19a. Informant's Name/Relations			i	•			-		
	l and lealth m 27 her tr	1	Lawrence Green	reid, Sor					Path Colum	D1a, MI c. Location - C		
altimore,	Pages 1 nent of H ont: If Ites ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from	n Siaib i		sition (Name of matory or other place					II, State
Ξ	rmit. Page spertment portent: If y injury o		'4 □ Donation 5 □ Other (S		Mt		non Cemet			delphi		
ä	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service	Licensee	mo				nes-Rinal			
m	80E 2 8		Osta				11800 New	<i>H</i> ampshi	re Ave Si	lver S	oring	MD 20904
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	h. Do not ent					1	Approximate interval Between
	Physician		Immediate Cause (Final	AH	long nor lo	Sofr	conde	arrilla	Muan	1	1	Onset and Death
	/Medical	1	disease or condition resulting in death)	aDue to	o (or as a consequ	uence of):	www	Much	() John M		1	790
Н	Examiner										0	
		er	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to	c (or as a conseq	uanca of j.						
	uted d ansit	m	Cause (Disease or injury that initiated events	S								
~	n an anial-tra	Examin	resulting in death) Last	Due to	o (or as a conseq	uence of):						
8760,	cate be executed physician and the burial-transit	dical		d.							55.80	
9	ficat g phy as the	edic									1	
×	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna					23d. Date	of deliver	v
Box	that the death cer ed by the attendin detached for use	ciar	in the past 12 months?		birth 2 Feta gnant at time of d		□Ectopic pregnancy □ Other (specify)	y		Mon	th C	Day Year
o.	the d	ysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unk			,, _					
٥.	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	P.	Part II. Other significant condition	ons contributing to	dedth but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	cco use contri	bute to the	cause of death?
ds,	signe d be	d by	Congerm	Spart.	Trulure				1 ☐ Yes	2 No	3 🔲 Proba	bly 4 Loknown
Record	w requir been si should	ete	Calledia	201/20	Nicens	1			24a, Was an	0.45 14		
Şeç	e law has l	ompleted	_ Crusova	(Ma)	BUSCOV				autopsy performe	l pi	rior to com eath?	sy findings available pletion of cause of
=		Cor								ZNo 1	Yes 2	2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?					*****	ath (Check only one)			
	d 15	2	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA	4	Home 5 Residen			
ם	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pendir	/8.44	te of Injury onth, Day Year)	28b. Time o Injury	of 28c. Injur	ry at / rk?	28d. Describe how	v injury occurre	ed	
0		atl	2 Accident investi	gation			M 1	Yes 2 □No				
Division of	or Attenated after death	tific	3 Suicide 6 Could 4 Homicide determ	sined 288. Pia	ce of Injury - At he Iding, etc. (Specif		reet, factory, office		28f. Location (Stree City or Town,		or Or Rural	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	A	1								
	Hospitel 24 hours a Funerel I	edical	29a. Certifier 1 Certifyii	ng Physician: To t	he best of my kno	owledge, deal	th occurred at the ti	me, date and place	e, and due to the cau urred at the time, dat	ise(s) and mar	ner as sta	ited. the cause(s)
	the H in 24 ihe F plete	edi	one)	and ma	anner stated.							
	To the within 2 To the complet	Σ	29b. Signature and title of certific				29c. Licens	se number	296	d. Date signed	(Month, D	Pay, Year)
)	7		MXT	VI			0000	105281		1/19/0	06	
	1		30. Name and address of person	who completed ca	use of death (Iter	m 23a) (Type	Print) /	1000	1.0.11	11	1,1	2000
			Husbrell L	Kright	MS	6/	21 Mm,	NOSE KC	1, Rocki	Mll 1	110	20856
	Sta	ate	31. Date filed (Manth Day, Year	32	Registrar's Signa	ature	male min					
	Regist	rar	IAN 21	2006	1 A. 15.1 1	CS 15%	4					

			1 - For State Registrar	State of Marylan		artment <i>rtificate</i>			ind Me		giene Reg. Nõ.	UUb	035	518
H	Physici	20	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day	Yea	r	of Death
	/Media		MEYER GREENBERG							January				50 A ^M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)		,		Location of	f Death		4c.	County of De		
			Casey House 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	kvi Year	If Under 2	24 Hrs.	8. Date of Birtl	h	9.F	gomery Lirthplace (Stat	e or Foreign
	Funeral Director			M 2□F 92	Yrs.		Days	Hours	Min.	Jan 2,	191	4 Nei	V York,	NY
	P.		Usual Residence of Decedent			1								
	arylar show	7	10a. State 10b. County	10c. City	y, Town or Lo	cation								City Limits es 2X No
	Ne M	Director	MD Montgomer	y S:	ilver						10 00			
	with t	ត់	10e. Street and Number	- 1 #505		10f. Zip (-	zen of What	•	
	leath	erai	3118 Gracefield Ro	2. Was Decedent Ever in U.	S. 13.	209 Was Decede		spanic Orio	in? (Spec	cify Yes or No-	-	ited Si	nerican Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itsm 27 is marked other than "natural", or itsma 23a or 28a-f show mingrant: If itsm 27 is marked other than "natural", or itsma 23a or 28a-f show my injury or other traumatic svent, the Modified Examinar must be notified at ance.	by Funerai	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1		lf Yes, speci 1 ☐ Yes 2	fy Cubai	Specify:	, Puerto P	Rican, etc.)		SpecifyWh:	nite, etc.	
Ö	natura	Completed	15. Decedent's Educ		16a. Dece	dent's Usual	Occupa	ation	of working		16b. Ki	nd of Busine:	ss/Industry	
2	thin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work DO NOT use	e retired,) most	OF WORKIN	9				
7	ed wi	Co		4	Sa	lesmar	1					inting		
Maryland	uld be fill Mental H arked ott	To Be	17. Father's Name (First, Middle, Last) Sam Greenberg							(First, Middle, Vaselev		Sumame)		
Mar	ind 2 sho alth and 27 is ma		19a. Informant's Name/Relationship (Type Paul Greenberg, Sc	•						Route Number Washin			, Zip Code) 20024	
Baltimore,	bages 1 and of He nt: If Itsm		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. P	lace of Dispo emetery, crer	esition (Name matory or oth	e of her place	9)	Da	ate	20c. Lo	-	or Town, State	
툹	artini injuri		21. Signature of Funeral Service License							es-Rina				Inc
m	De grand		I alay 2	Donnell						Ave Si				
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Acute Lymph	oma	er the mode	of dying	g, such as c	cardiac or	respiratory ar	rest,		Approxin Interval I Onset ar	Between
- 6	Examiner			Due to (or as a consequ	uence of):									
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):									
	sate be executed only sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	oe execian a	Ě	resulting in deathly cast	Due to (or as a consequ	uence of):									
87	physic the t	dical	, d.					_	_					
9 X	eath certific ettending p	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncy						1	23d. Date of o	lalivan:	
O. Box	The law requires that the death certific Ite has been signed by the ettending p page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pre Other (spe			<u> </u>			Month	Day	Year
О.	that the ed by detach	Phy	Part II. Other significant conditions cont	tributing to death but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribute	to the cause of	of death?
rds,	w requires been signe should be						g., c						Probably 4	
000	e law requ has been je 2 shouli	Completed								24a. Was autop		24b. Were	autopsy findin o completion o	gs available
<u> </u>	Physician: The la rthis certificate has ral director, page 2	Con								perfor	rmed? 2 XNo	death	? es 2□ No	
ita	cian: ertific actor,	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	ne)			
<u></u>	Physician: rthis certifica ral director, p	ို	TI Tes 213/40		ER/Outpatier			4 🗀 1401		e 5 🗆 Resid			pecify)Hosp	ice
L C	Jing F	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		Bc. Injury Work			8d. Describe h	low injur	y occurred		
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	M reet, factory,		/es 2□N		8f. Location (S City or Tow			Rural Route N	lumber,
_	To the Hospital within 24 hours a To the Funeral I completely filled	edicai Ce	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	wledge, death	h occurred a	it the tim	e, date and inion, death	d place, ar	nd due to the o	cause(s)	and manner place, and d	as stated. ue to the caus	e(s)
	To the within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated.				number					nth, Day, Year	
			12 1 2	landia = c									19, 20	
7	10		30. Name and address of person who cor	Tolored govern of death (11	222) /Tun-		4245)						
			Chitra Desikan Raj				e Ph	illio	Dri	ve #32	7 01	ney MD	20832	
6	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa		the state of		E				-		
	Registr	ar	IAN 2 0 200	h Passes N	- ALLES	B. B. Car								

			1 - For State Registrar	State of Ma	•	epartme <i>Certifica</i>			ind Me		iene	6	03519
			1. Decedent's Name (First, Middle, Las.	t)						Date of Deal Month	th Day	Year	3. Time of Death
	Physici /Medio		James C. Goodwin	Ĺ						January		06	4:30 P ^M
)	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or	Location o	f Death		4c. County	of Death	
			Holy Cross Hospi	tal		Si	lver	Sprin			Montg	omer	у
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birtl	hday) If Und Months	or 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day July 17	Year)	9. Birthp	place (State or Foreign
	Director		250-10-2464	X M 2□ F	92 _Y	rs.	Days	110013		July 17	, 1913		th Carolina
	P .		Usual Residence of Decedent		10.00								
	anyle show	Ļ	10a. State 10b. County		10c. City, Town							'	0d. Inside City Limits XXYes 2 □ No
	e Mi	cto	Maryland Montgome	ery	Silver	Sprin	g						
	ith th	O Pre	10e. Street and Number	_		1	ip Code			1	0g. Citizen of V		•
	within 72 hours after deeth with the Marylend ene. than "natural", or iteme 23a or 28a-1 ehow ha Medical Examinar must be notified at	by Funeral Director	2501 Musgrove Ro				20904				United		
	en de	ne	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dec	edent of H ecify Cuba	ispanic Orig an, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		e - Ameni k, White,	ean Indian, etc.
36	or i	ΥF	1 Never Married 2 Married	1 ∐Yes 2 🛣 If Yes, Give	No	1 ☐ Yes	2 X No	Specify:			Specifi	<i>/</i> :	
21215-0036	urai		3 XWidowed 4 □ Divorced	Year or Dates:							Atri	can	American
5	nat	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a.	Decedent's Us (Give kind of v	rork done	during most	t of workin	g	16b. Kind of B	usiness/in	dustry
121	withir noe.	du	Elementary/Secondary (0-12)	College (1-4or 5	5+) D	iite DO NOT lumber	use remed	2)			Dropri	atar	(Plumbing)
2	iled Hygie her i	ပိ	17. Father's Name (First, Middle, Last)			Tamber		18 Mothe	r'e Namo	(First Middle	Maiden Suman		(LIGHDINE)
an of	d d d	To Be	Randolph H. Goodw	ri n						t Dowdy	maroon obritain	.0/	
Ž	Dould Marke Marke	P	•		405	44- C Add	(04		<u> </u>		- C'2 T	Ot-1- 70	0-4-1
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show minjury or other treumatic event, the Maritial Examinar must be notified at once.	V S	19a. Informant's Name/Relationship (7) Rebecca C. Shaw	(sister)		•				er Spri	r, City or Town,		- •
ď	l and lealth	1		(SISCEL)						ate Shir	20c. Location -	2090	
Baltimore,	T it	1 3	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	1	Disposition (N		(B)		100			
Ë	Pant:		4 Donation 5 Other (Specify)	Gates	of Hea			1/21		Silver		
ăa	Depenition Dependent Important In Procession Contract In Procession Contract In Contract I		21. Signature of Funeral Service Licen:	see /							neral S		
ш	40 E # 9		Undre tho	roody		7400	Geor	gia A	ve. l	N.W., W	ash. D.	C. :	20012
7	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aSepsi	ne. S a consequence o		ode of dyin	ng, such as	cardiac or	r respiratory ari	est,		Approximate Interval Between Onset and Death Days
8760,	thet the death certificate be executed ed by the ettending physicien and deteched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of								Days
.O. Box 68	the death certifica by the ettending phached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (′				te of delive	ery Day Year
0	w requires thet the been signed by th should be deteche	ed by PI	Part II. Dther significant conditions of Dementia	ontributing to death b	out not resulting in	the underlying	cause giv	en in Part I					he cause of death?
Records,	hesb hesb	omplet								24a. Was a autop perfor	sy med?	Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of
ita	sician: Th certificate irector, peç	BeC	25. Was case referred to medical					26. Place	of Death	(Check only or			
>	Q is	To E	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ent 2 ER/Out	tpatient 3	OOA Oth	ier: 4 🗆 Nu	ırsing Hon	ne 5□Resid	ence 6 Oth	ner (Speci	fy)
0	g Ph er th	2	27. Manner of Death	28a. Date of Inju	ury 28b. T	ime of	28c. Injur Wor	y at	2	28d. Describe h	ow injury occur	red	
<u>0</u>	nding F sth. r: After e funera	읉	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ly / Gai/	M		Yes 2	No				
Division of Vital	al or Atte s after de il Directo ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of in	jury - At home, fai tc. (Specify)	rm, street, fact	ory, office		2	28f. Location (S City or Tow		ber or Rur	al Route Number,
	To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier Check only one) Certifying Ph	ysician: To the best niner: On the basis of and manner st	of examination and	, death occurre d/or investigati	ed at the time on, in my o	me, date an opinion, dea	nd place, a th occurre	and due to the d ad at the time, d	ause(s) and m date and place,	anner as s and due t	stated. o the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier			2	9c. Licens	e number			29d. Date signe	d (Month,	Day, Year)
	1		1 July	Me			D 3	2332		Ì	Januar	y 16	, 2006
	•		30. e and address of person who	completed cause of	death (Item 23a) ((Type, Print)							
750			Surreh K. Gupta,	M.D. 980	1 Georgi	a Ave.	Sil	ver S	pring	g, Mary	land 2	0902	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Régist	rar's Signature	Speak	9						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Janth. **Physician** Orville 17ª 2008 4:15 pm м Gossett /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Crofton Convelescent Center Crofton Anne Arundel Hours Min. July 16, 1915 If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Ohio XX M 2□ F 365-03-4450 90 Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h Counts r than "netural", or Itams 23a or 28e-f show the Medical Examinar must be notified at 1 Yes XXNo Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Silo Ridge Court Apt. 101 21113 United States Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural". ... in any Injury or other traumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 XXVo Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1941-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Power Plant 9 Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae Barthalowe unknown ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 Silo Ridge Court Apt. 101 Odenton, MD 21113 Katherine Gossett/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Metro Crematory 1/20/2006 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician orelrovarula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner hysician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as t IE FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Tunknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 №No 24a. Was an Dementica autopsy page 2 No certificate 1 Yes Division of Vital Hospitel or Attanding Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐No P 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 🗌 Yes 2 🗆 No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To tha the 29d. Date signed (Month, Day, Year) 29b. Signature and title of con-29c. License number 0 19/2000 death (Item 23a) (Type, Print) of person who completed cause ryhway Sw alen Burnee MD 21061 208 Crain State Registrar

			1 - For State Registrar	State of M	aryland		artment tificate			ınd M		jiene	5	0352	21
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month		Year	3. Time of	Death
	Physici		Marilyn Jean G	lovinsky									006	9:30	рм
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	}		4b. City,	Town, or	Location o	f Death		4c. County of	of Death	•	
*			Montgomery Hospi	ce- Casey	House	<u> </u>	Roc	kvil	le			M	onto	omery	
. Q.	Funeral		Social Security Number 6. S	ex 7. Ag	ge (In yrs. la		If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day April I	Year)	9. Birthr	place (State on htry) .chigar	r Foreign
12	Director		300-30-8337	UM 2UF	74	Yrs.					Aprill	5, 1931	Mı	.chigar	1
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	. Town or Lo	cation			-				0d. Inside Ci	ity Limits
	/anyli	ö	Maryland Montg	omerv		Silver	Snri	na						1 🗌 Yes	≨ ⊠ No
	28a-	ect	10e. Street and Number	Olice Ly		711461	10f. Zip					10g. Citizen of W	hat Cou	ntry?	
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	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itema 23a or 28a-f show thit, the Micdical Examinational Leandillied at	Completed by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.)	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Race		can Indian,	
9	after or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces'		1	1 Yes, spec 1 □ Yes 2			, Ривпо	Hican, etc.)	Specify:	k, White, White		
03	ral', c	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			10 195 4	AEI NO	зреспу.			эреспу.			
5	72 h	etec	15. Decedent's E (Specify only highest gra			16a. Deced (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation Ju <i>ring</i> most	of worki	ng	16b. Kind of Bu	siness/In	dustry	
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7	lled v tygie ther t	ပိ	17. Father's Name (First, Middle, Last,)		Sai			18 Mothe	r's Name	/First Middle	Maiden Sumami			
Maryland 21215-0036	d be f	o Be	Alex Ross								Lovinge		,		
7	Shout mark matt	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)	
, Ma	and 2:		Renee C. Raible/	Daughter	lan su	200 ===			Road,			ring, MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show many injury or other traumatic event, the Michael Examinating at Annexe.		20a. Method of Disposition 1 Burial 2 Toremation 3 4 Donation 5 Other (Special		Ce	ace of Dispo emetery, crer opolita	natory or o	ther plac	10	anua	oate 1ry 19,	20c. Location -	enese s		
alti	mit. F partm portal rinjui		21. Signature of Funeral Service Lice			22	2. Name an	d Addres	s of Facilit			Alexand Home I		VILGI	Jala
m	Depar Depar Impor any ir		Denin 21.	Sili		5	00 Un	iver	sity	Blv	W, S	llver Sp	ring	, MD 2	20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death line.	. Do not ent	er the mod	e of dyin	g, such as	cardiac (or respiratory ar	rest,		Approximat Interval Bet Onset and	tween
	Physician		Immediate Cause (Final disease or condition	Breast	Cancer	<u>c</u>								Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):									
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	death certificate be executed e attending physician and d for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as										_	
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687	icate phys s the			d											
Вох (eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_					23d. Date	e of deliv	ery	
	death e atte d for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a			∃Ectopic pr ∃ Other (sp					Mor	nth	Day	Year
P.0	that the ed by the detache	hys	9 ☐ Unknown	9□ Unknown							1340			-	
	res that the de signed by the a be detached f	by P	Part II. Other significant conditions	contributing to death	but not resu	ılting in the u	nderlying c	ause givi	en in Part I.			bacco use contr			
ord	law requires as been sign 2 should be										1111	′es 2. ⊠No	3 ∐ Pro	bably 4 🔲	Unknown
Records,	elawr hasbe je 2 sh	Completed									24a. Was autop	sy p	rior to co	opsy findings impletion of c	available cause of
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Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only o	-	_		
of	Physic this c	10	1 Yes 2 No	1 🗆 Inpat		ER/Outpatier			4 🗆 190			lence 6 🖾 Othe		_{fy)} Hospi	LCe
n (dlng F After funera	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	M Z	28c. Injun Worl	γαι k? Yes 2		260. Describe i	now injury occurr	eu		
isic	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	De Diago of Ir	niury - At ho	me farm st			163 2	-	28f. Location (5	Street and Number	ar or Rur	ai Route Num	n.ber.
Division of	tal or Attend is after death al Director; v	Certification:	4 Homicide determined	building, e	alc. (Specify)		y, omoo			City or Tox				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Pi	hysician: To the bes miner: On the basis and manner s	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the tin , in my o	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as a	stated. to the cause(s)
	To the To the Corrigion	Ž	29b. Signature and title of certifier	1			290	c. Licens	e number			29d. Date signed	(Month	Day, Year)	
	10		1 Le	<	~	2			35635	5		Janua	ry 1	9, 200	06
	•		30. Name and address of person who												
-23.2	200-		1 1				Mill	Road	, Roc	ckvi	lle, MD	20855			
	Sta Regist		31. Date filed (Mooth, Day, Year)	996 32 Regis	trar's Signat	A Ap	ante "								

		•	101	partment of Health and M Prtificate of Death		ene 0 0 6	03522
			Decedent's Name (First, Middle, Last)		Date of Death Month	1	3. Time of Death
	Physici /Medic		RAPHAEL ANDRE HII	L	JANUARY	20 2006	6:30 P
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			WASHINGTON ADVENTIST HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	TAKOMA PARK If Under 1 Year If Under 24 Hrs.	8 Date of Birth	MONTGOMER	
	Funeral Director		578-74-2069 1™ 2□F 52 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, APRIL 3	1953 WAS	nplace (State or Foreign untry) HINGTON, DC
	yland now		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Finast be notified at	ctor	MD PRINCE GEORGE'S GREENBE	ELT			1X Yes 2 □ No
	ith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	s 23a	ral	9160 EDMONSTON ROAD # 103	20770	7. 24	U.S.A.	- today
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show avant, Ita Medical Exactiver must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spenif Yes, specify Cuban, Mexican, Puerto □ Yes	eciny Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
2-0	72 ho	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of works	ing	6b. Kind of Business/I	Industry
121	filed within 72 Hygiene. rther than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) S OPERATOR		PRIVATE	
0 7	filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, N		
an		To Be	MELVIN S. HILL	MARY A	A. BROW	N	
ary	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rura	al Route Number,	City or Town, State, Z	(ip Code)
	and 2 ealth m 27					ELT, MARYLAI	
Baltimore,	000-		TEADURAL 2 COMMUNICAL TOTAL STATE	ematory`or other place)		loc. Location - City or	
				JET CEMETERY $1/28$ 22. Name and Address of Facility J.		WASHINGTON	
Ba	permit. Departr Imports any inju			474 LANDOVER ROAD			20770
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition resulting in death)	arrhosis			Onset and Death
B	/Medical Examiner		Due to (or as a consequence of):	*			
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۵.	es that gned b	by Pł	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	. /
ord	w require been sig should b	ted			1 Te	s 2□No 3□Pro	obably 4 Unknown
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Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ER/Outoat	26. Place of Death			-7.1
0	Attanding Physician: If death. actor: After this certific by the funeral director.		27. Manger of D ath 28a. Date of Injury 28b. Time	of 28c. Injury at		nce 6 Other (Spec w injury occurred	city)
Ö	andin ath. or: Aft	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	tal or Attanding is after death. al Diractor; After ed in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
	To tha Hospital or Attanding Phyqibin 24 hours after death. To the Funaral Diractor: Atter the completely filled in by the funeral	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the comple	Σ	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Mont/	DI / DA
	Q. E		30. Name and indirection of person in completed cause of death (Item 23a) (Type	e, Print)	01.	Adin.	Lot Maga
	Sta		31. Date filed (Modin, Jaly, Year) 32. Registrar's Signature	/ VV (The	Han	Jalland	77 1717/
	Registi	ar	THE TOUR PROPERTY OF THE PROPE				

State of Maryland / Department of Health and Mental Hygiene 03523 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Holland Mary Maggie 19,2006 January 0040 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 19, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 217-32-4482 82 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neture!, or items 23a or 28e-f show other traumatic event, its Madical Examinar must be notified at 1 Yes 2 No ⊉Maryland Calvert Huntingtown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4890 Solomons Island Road 20639 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene.
ant: If item 27 le marked other then "neture!; ury or other treumatic event, its Medical Enury. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hotel Housekeeping Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ρ. Holland Lillian James Green 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, M 14904 Mt. Calvert Rd. Francis Holland/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If eny Injury or office. UMC Cem.1/25/06 Plum Pt. Huntingtown, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensee Blodys a. 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA OF **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner as been signed by the attending physicien and 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ erilenilia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 Inpatient 2 EP/Outpatient 3 DOA t ☐ Yes 2 ☐ No. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 19427 Physica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD 20678 Anwar T. Munshi, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Reg State JAN 20 Registrar

		State of Maryland / Department of Health and 1- State Registrar Certificate of Death		giene 06	03524
GO L	- Bin	Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
Physicia /Medic	_	Catherine Louise Huntzberry	Jan 20	2006 Year	0200 M
Examin		4a. Fecility Name (If not institution, give street and number) 2010 Woods Road 4b. City, Town, or Location of Death St. Leonard	h	4c. County of Deat Calvert	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F F 6.3 Yrs. 6. Sex 1 Months Days Hours Min.	8. Date of Birt (Month, Day Dec 13	v, Year) Co	nplace (State or Foreign untry) Cyland
laryland ehow		10a. State 10b. County 10c. City, Town or Location St. Leonard			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ith the M or 28e-f	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
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y Men J Men narke	2	Francis Buehler Bert		ood	Fig. Co.do.
Mand thand traun		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Ri</i> John M. Huntzberry- son 4825 Egret Ct. Pri			
s 1 and the at item 2		20a. Method of Disposition 20b. Place of Disposition (Name of			
Page Page nent o ant: #		20a. Method of Disposition 1	tefy	ort Repub	olic Maryla
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necolds, he law requires t e hes been signe age 2 should be o	Completed			prior to death?	topsy findings available completion of cause of
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To the Hospital or Attending Physician: The law within 24 buours after death. To the Funeral Director After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide Accident	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
Hospital 24 hours : Funeral	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
vithin Fo the	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Monti	h, Day, Year)
. , , , ,		Kioumate Yazdani D17168		1/20/06	
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Yazdani, M.D. Huntingtown MD 20639	· · · · · · · · · · · · · · · · · · ·		
Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrate Signature JAN 2 5 2006 Masses & Continues			
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	/Medic		4a Facility Name (If not institution, give					4b. City, Town, or	January Locetion of Death			2:14A
	Examin	eı	Ft. Washington Hos					Ft. Wash	nington	Princ	e Georg	ge's
· F	uneral		5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bir			(State or Foreign
	irector		180-10-4062	M 200 F 83	3	Yrs.	MOINTS Days	Tiours will	May 26	1922	Pennsy.	Lvania
pue	3	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				10d. I	nside City Limits
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tha A	28a-	20	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?	21
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Jeath	THE 25	era		12. Was Decedent E	ver in U,S.	13. V	Vas Decedent of I	Hispanic Origin? (Specify Yes or No		e - American Ir	idian,
o site	P P	[교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X XNo	0			an, Mexican, Puè	to Rican, etc.)		ck, White, etc.	
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			Howard S. Paules						a A. Swa		.0)	
aryla should I	marked matic e	٩	19a. Informant's Name/Reletionship (Ty)	ne Print)	1	9b. Mailin	a Address (Street	and Number or R			State. Zip Cod	(e)
_	27 is trau		William E. Hockman					Dr. Oxon				-,
9 - i	tem other	- 1	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	100	Date	20c. Location -	City or Town,	State
Pages	y or		1 ☐ Burial 2X Cremation 3 ☐ R 4 ☐ Donation, 5 ☐ Other (Specify)	emoval from State		-	matory or other pla ematory	ice)	1/25/06	Edgewat	er.Mar	vland
Saltimore, pamit. Pages 1 ar	important: If it any injury or o once.		21. Signatur Funeral Service License	e /	Kara			ess of Facility Ge		-		
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Phy	sician		shock, or heart failur of List only of	cause on each line	9.						Inte	rval Between set and Death
	edical	- 1	Immediate Cause (Final disease or condition	ADULT	RESP	IRA	TORY	DISTOF	Y2 25	NDONA	E	
Exa	miner		resulting in death)		ue to (or as			10 -1 20		112/2011		
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D&/OL licate be	physic the b	음 	that initiated events resulting in death) Last		ue to (or as	a consequ	uence of):					
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DOX	for us	ä								,		
	ched	ysi	Part II. Other significant conditions con	tributing to death but	not resulting	g in the ur	nderlying cause gi	ven in Part I.				cause of death?
that the	ed by deta		HYPO ALBUMI	NEMIA	5				1	Yes 2□ No	3 ☐ Probably	4 Unknown
cords requires	been signed by the atte should be detached for	d by							24a, Was	an autopsy		utopsy findings
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The law	has iga 2	틹							101	Yes 20Mo	-	s 2 No
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To the Hospital or within 24 hours effe	Vo the Funeral Director: After the complataly filled in by the funeral	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin									
the H	the F		one)	and manner state					1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
° ± ×	200	Σ	29b. Signature and title of certifier	PHYSIC	MAL)	29c. Licens		2	29d. Date signe		
	(6)		MAN	. 11(2)	~ /			5378		MAC	义4	2006

Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH VERGHESE 170 LIVI

31. Date filed (Month, Day, Year)

JAN 2 6 2006

LIVINGSTON

ROAD

SUITE # 101, FORT

WASHINGTON

Ame	ndeđ#s		For 18, 19a, 19b Registrar	State of Ma	ryland / De	epartment of F Certificate of	lealth and M <i>Death</i>		iene 2006	03526
et*	Physicia		1. Decedent's Name <i>(First, Middle, La</i> Blanche	31)	lizabeth	Har		2. Date of Deat January 2		3. Time of Death 2:35 A M
	/Medic Examin		4a. Facility Name (If not institution, giv Manor Care Health Ca			4b. City, Town, o.	r Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 6, 1	Year) 9. Bir	thplace (State or Foreign buntry) cyland
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	erv	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 20 No
	death with the Maryland ms 23a or 28a-f show Lindst be mulling at	Director	10e. Street and Number 10517 MacArthur Blvd	-		10f. Zip Code 208	354	11	0g. Citizen of What Co	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinations to the intiffied and once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 276N If Yes, Give		13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
215-00	hin 72 hour 9. nn "naturai Medical Ex	Completed b	15. Decedent's E (Specify only highest gr.	Year or Dates: ducation ade completed) College (1-4or 5-	(C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of work		16b. Kind of Business	
Baltimore, Maryland 21215-0036	be filed wit ntal Hygiene od other the	Be	12 17. Father's Name (First, Middle, Last)	-	Security Assi	18. Mother's Nam		Federal Gover Maiden Sumame) chards	nment
Maryla	nd 2 should lih and Mer 27 is marke traumatic	은	Edward V. Richard 19a. Informant's Name/Relationship (James E. Hardy Sr. /	Type, Print)	19b. A	Mailing Address (Street 0517 MacArthu	and Number or Pur	al Route Number	City or Town, State,	Zip Code)
more,	Pages 1 ar nent of Hea int: if item iry or othe		20a. Method of Disposition 1378Burial 2 Cremation 3 (4 Donation 5 Other (Speci		20h Place of D	isposition (Name of crematory or other plac Episcopal Cen		Date / 06	20c. Location · City or Forestville,	
Balti	permit. Departmine imports any inju		21. Signatur of Funeral Service Ince	as it		6160 Oxon	Hill Road	Oxon Hill.	as Funeral Ho , Maryland	20745
	Physician		23a. Parri. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			enter the mode of dyir noma Metastas		or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chronic C	a consequence of) Destructive a consequence of)	Pulmonary D	isease with	exacerbat:	ion	
,0	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	n Thrombosi a consequence of)					
κ 68760,	certificate by nding physic use as the bu	Medical	IF FEMALE:	d. Bronchiti						
P.O. Box	death e atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2Å No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions Atherosclerotic Card	•	•	ne underlying cause giv	ven in Part I.		pacco use contribute t es 2 □ No 3 □ P	o the cause of death?
I Reco	aw s b	Completed						24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The I wilty, 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 Vo 27. Manner of Death 1 XXN atural 1 Accident investigatic	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day		ne of 28c. Injur	ry at	ome 5 Reside	e) ence 6 □Other (Special Communication) ow injury occurred	ecify)
Divisi	al or Attending after death. I Director: After d in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not to determined		ury - At home, farn c. (Specify)	n, street, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	edlcal	29a. Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/	or investigation, in my o	opinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	To To com	Σ	29b. Signature and title of certifier	i Vo	hron	29c. Licens D-202			9d. Date signed (Mon $1/24/06$	th, Day, Year)
	Se	10	30. Name and addr s of person who Kriti A. Vohra, M.I). 7710 Bradl	ley Blvd. H	ype, Print) Bethesda,MD. 2	20817			
	. Sta Registi		JAN 2 6 2006	32. Registra	ar's Signature	•				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 0942 Jean Barbara Heuris 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 606 Liberty Street Wicomico Salisbury If Under 24 H 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** January 13, 1953 Months Days 1 M 2 M F Yrs. Maryland Director 214-60-7640 53 Usual Residence of Decedent 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinat must be notified at 1X Yes 2 □ No Directo Maryland | Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Liberty Street Funeral 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ρ Specify: 3 Widowed 4 N Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Cleaning Housekeeping permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert James West Kathleen Ethel LeCates West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen West/Mother 606 Liberty Street Salibsury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 1/27/06 Salisbury, Maryland nature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. CFSP 501 Snow Hill Rd. Salisbury, Maryland 21804 Googmod 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 1 Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): as attending p ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Trobably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy nedormed? 2 110 certificate 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ۵ 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending investigation ul or Attendina safter death. I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ompleted cause of death (Item 23a) (Type, Print)

DIME

32. Registrar's Signature

(00)

1).0

Ecural St.

29d. Date signed (Month, Day, Year)

21801

requires that the death certificate be executed

The law

Physician:

Box 68760,

Records, P.O.

Division of Vital

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier

29b. Signature

30. Name and address of person wh

hris

31. Date filed (Month, Day,

1618 West Rd. Salisbury MD 21801 Sali)		•	1 - For State Registrar	State of Maryland	•	tment of F		•	giene Reg. No.	06	03528
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State IAN 2 C 200Cl See		IVA		4				STREET	BALTIMOR	E, MAI	RYLAND	21201
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Physician Medical Examinor Relizabeth Houseman de Poul House Manual Control			•	For State Registrar	.000	State	of Mar	yland /		artmen rtificat			and M	lental Hy	giene Reg. No	UUC	0	352	9
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Control of Description Control of Descript	Ex	amine		10819 Rock	Run	Drive				Po	toma	ć				Montg	omery		
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23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Causey Final Property of the Causey Final	, Mary and 2 sho alth and 1	ar treume						15										ode)	
23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Causey Final Property of the Causey Final	More, Pages 1 a ent of He nt: If item	O or other		1X□ Burial 2 □ Crema			n State	I										n, State	
Sequentially list conditions, large graph of the sequence of lists and	balti permit. Departm Importe	any inju		21. Signature of Funeral Se	vice Licer	e Jarfa	ec.		22	2. Name an	d Addres	s of Facilit	y Jos	eph Ga	wler	's So	ns,IN		j
ODE TO COLORS (Life to Underlying) The part of the pa	/Med	lical iner	1	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or com List only	a. Bre	each line.	Cancer	r Wi:								In	pproximate Iterval Betw Inset and De	een
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	cate be executed physician and	ng eu	cal	Cause (Disease or injury that initiated events	1	c		,											
The state of the s	the death certifi	or use as	ysiclan/Me	23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No	t	1⊡Live 4⊡Preg	birth 2 nant at tim	Fetal dea				HII- HI					,	ay Ye	ear
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the within 2	complet			ortifier	and ma	nner state	hd. hD										y, Year)	
	6			30. Name and address of pe	rson who					Print)					Jail	اے و ل			
Robert Dyer M.D. 5530 Wisconsin Ave, Chevy Chase, MD 20815 State Registrar JAN 2 4 2006 Robert Dyer M.D. 5530 Wisconsin Ave, Chevy Chase, MD 20815	Re			31. Date filed (Month, Day,	(ear)	5530	Wisc Registrar's	onsin s Signature	Ave	, Chev	y Ch	ase,M	ம 20	815					

			1 - State State Registrar		artment of Health and rtificate of Death	Mental Hygie	2000 00000
3			Decedent's Name (First, Middle, Last)		·	2. Date of Death	Day Year
	Physici /Medio		HOA THI HUYNH			January	18 2006 7:10 P M
) esis	Examin		4a. Facility Name (If not institution, give street and r.	number)	4b. City, Town, or Location of Dea	ith	4c. County of Death
	1 2	£17	Laurel Regional Hospit		Laurel		Prince George's
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 Hr: Months Days Hours Mir	1. (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		578.19.3583			April 26,	1931 Vietnam
	yland H ow		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
:	e Wa	ctor	Maryland Montgomery	Silver S	Spring		1X Yes 2 □ No
:	death with the Maryland ms 23a or 28a-f ahow rittual be notified at	Directo	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
:	8 23a		1909 Treetop Lane, Apt		20904		Vietnam
	items Items	Funerai	Armed	ecedent Ever in U.S. 13.1 Forces? 1	Was Decedent of Hispanic Origin? (Il Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
9500	Il' or	by F	1 Never Married 2 Married 1 Yes, 0 3 Widowed 4 ⊠Divorced Year or	Give	1 ☐ Yes 2 ☒ No Specify:		Specify: Asian
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-61212	e	npie	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	kind of work done during most of wo DO NOT use retired)	orking	Damantia
7	ygien ygien t,	Completed	6th	Но	usewife		Domestic
Jand	ital H d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Mail	den Sumame)
<u> </u>	narke natic	은	(Unknown)	4.0h Adailte	ng Address (Street and Number or F		in as Town Chain Tin Codel
Z	permit. Fages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or Nems 29a or 28a-f show any injury of other traumatic event, tra Medical Examinat must be notified at once.	1	19a. Informant's Name/Relationship (Type, Print) Ann Nguyen/Daughter				ver Spring, MD 20904
<u>ق</u>	We fig a		20a. Method ol Disposition		esition (Name of matory or other place)	CONTRACTOR OF THE PARTY OF THE	Location - City or Town, State
aitimore,	A = 10 S		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		oln Crematory1/2	2/2006 Br	entwood, Maryland
	mart. Partmoortar		21. Signature of Funeral Service Licensee	and the same of th			
ă	B a li b		Namy A. Vere		NES-RINALDI FUNE 800 New Hampshir	RAL HOME, e Ave, Sil	INC. ver Spring,MD 20904
34		200	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or				
F	hysician		Immediate Cause (Final disease or condition Stro	-			Onset and Death
	/Medical		resulting in death)	o (or as a consequence of):			
	Examiner		Sequentially list conditions, b. Resp	iratory Failur	e e		
1	slt ed	ine	cause. Enter Underlying	o or as a consequence of			
	and and II-trar	Examiner	that initiated events c. II V C	rtension o (or as a consequence of):			
00/0	certificate be executed ding physicien and use as the burial-transit	dical E					
20	g phy as the	edlo	u				
XON .	w requires mat the deam certific been signed by the attending p should be detached for use as	Physician/Me	23b. was decedent pregnant	outcome of pregnancy	Ectopic pregnancy		23d. Date of delivery
	e atten	sicia	1 Yes 2 No	gnant at time of death 5	Other (specify)		Month Day Year
י כ	at me	hy	3 🗆 Onknown				
'n	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
orc	nedul pould	ted	Under Nutrition			1 Tes	2X No 3 Probably 4 Unknown
Records	te has b	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
_						1 ☐ Yes 2 🛣	
Vital	rnysician: The law this certificate has trail director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:	Inpatient 2 ☐ ER/Outpatien	Other	eath (Check only one)	a Clay (a . ()
ō	ar this eral dir		27. Manner of Death 28a. Dat	te of Injury 28b. Time of	f 28c. Injury at	28d. Describe how	e 6 Other (Specify) injury occurred
0	Attending ir death. ector: After by the funer	atio	1 🖾 Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	onth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
noision	er de recto by th	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla	ce of Injury - At home, larm, str Iding, etc. (Specify)	reet, lactory, office	281. Location (Stree City or Town, S	at and Number or Rural Route Number,
ַ בֿ	rel Di	0		g, (-F)/		3.75.75	
	To the chospiel or Attending Prity within 2 Hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai	(Check only 2 Medical Examiner: On the	basis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the caus	e(s) and manner as stated. and place, and due to the cause(s)
:	thin 2 the mplet	Med	one) and ma	anner stated.	29c. License number		Date signed (Month, Day, Year)
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	3		30. Name and address of person who completed ca	iuse ol de th (Item 23a) (Tune		*	2000,
			KAMALINGE V. DE	SUPANDE:	4D, 6001 Lux	have	San 19th 2006. Rockville, MD
	Sta		31. Date filed (Month, Day, Year) 32.	flegistrar's Signature	rack !		
	Registr	rar	JAN 24 2006	Marco St. 19	A DOWN PROPERTY OF THE PROPERT		

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Box 68760,	
P.O.	
Vital Records, F	
Division of	

96249		1 - For State Registrar		-	epartment of F Certificate of		Reg. I		03531
Dhuniai		1. Decedent's Name (First, Middle,	Last)			2.	Date of Death	Year Veer	3. Time of Death
Physici /Medi		Ho Cheung Ho					NUARY	19th au	of 1:33 P
Examir	er	4a. Facility Name (If not institution,				r Location of Death		4c. County of Deat	th
			Sex 7. AC	1 TAL		IMORE	Date of Birth	9 Rim	thplace (State or Fore
Funeral Director		219-29-2905	1 ⊠ M 2□F		rs. Months Days	Hours Min. S	Date of Birth (Month, Day, Yea ept. 20,	1936	thplace (State or Fore cuntry) China
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lin
r 28e-f show	ō	Maryland	_	Baltim					1 🖺 Yes 2 🗍
286	Director	10e. Street and Number		Darti	10f. Zip Code		10g.	Citizen of What Co	ountry?
3a or	<u></u>	3005 Overland A	venue		21214	•	Un	ited Sta	tes
ene. than "natural", or items 23s or 28e-f show ts Medical Ezamiter must be mutilled at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of H	lispanic Origin? (Specifi an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
ral, or Exami	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 점 If Yes, Give Year or Dates:	NO	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
"natural", clical Exa	eted	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	eation during most of working	16b.	Kind of Business	/Industry
nd Mental Hygiene. marked other than " imatic event, the Ne	Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT use retired 1f Employed			Retail	
ital Hygiene. id other than event, the M	0	17. Father's Name (First, Middle, La	`			18. Mother's Name (F	irst, Middle, Maid	len Sumame)	
Menta vrked ttic ev	To B	Zhi He				Yue Yang			
Depertment of Health and Menta Importent: if frem 27 is marked eny injury or other traumatic events.		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street 154 Darnest	and Number or Rural R	oute Number, Cit	y or Town, State, J	Zip Code)
tealth im 27 her ti	1	Hiu Fung Ho/ So	n	Ga	ithersburg, Disposition (Name of	Maryland 2	20878		T 0
الم الم		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cemeter Nat	r, crematory or other place.	Januar	y 26,	Location - City or	
ntmer		4 □ Donation 5 □ Other (Special Signature of Funeral Service □	1 1		al_Park	2006			ch, Virgii
Depe Impo		J. Signature dy Funeral Se MC8		0689	1	ss of Facility DeVo. Drive, Gait		-	
, 13		23a Part 1 Enter the disease, or c	omplications that cause	d the death. Do n				6, IIII) I.	Approximate
nysician		Immediate Cause (Final	ny one cause on each i	ine.					Interval Between Onset and Death
Medical		disease or condition resulting in death)	Due to (or as	al fai	tice			Get "	/1.
xaminer		Sequentially list conditions	Hupo	Tensio	in ound a	cul lubi	ularne	CLOSES	HUAY
ž	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	100	a consequence o	f):	cub lub	å		4 i
and I-trans	Examine	that initiated events resulting in death) Last	c. Herry	a conseque	of no	avceu	ular c	encinori	a 4DAY
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sicien buria	a								
physicien and is the burial-transit	edical		d						
anding physicien use as the buria	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	205			23d. Date of de	livery
the attending physicien hed for use as the buria	siclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome	2 Fetal death	3 ☐ Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
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State of Maryland / Department of Health and Mental Hygiene 1 1 5

03532

				•	Cert	ificate of	Death	,	Reg. No.	0000
	- · · ·		1. Decedent's Name (First, Middle, Las	st)				2. Dete of Dee	oth Dev Year	3. Time of Death
	Physici /Medi		JOSEPH	HAROLD	HARBA	UGH		JÄNÜAI	RY 25,200	6 2:50 P.M.
	Examir		4e Fecility Name (If not institution, give	•			4b. City, Town, or L	ocation of Death		
1		ę .	Julia Manor H	ealth Care	Center		Hagers		Washi	
٦	Funeral Director		213-14-2300	ex 7. Age (In yrs	s. lest birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day Februs	^h , Yeer) 27, 19	rthplace <i>(State or Foreign</i> Suntry) 17 Marylan
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loca	ation				10d. Inside City Limits
	a Maryl Sa-f sho puttied s	ctor		ington	Hagers	,				1X☐ Yes 2☐ No
	th with th	Funeral Director	10e. Street end Number 333 Mill Street	5		10f. Zip Code 2174	0		10g. Citizen of What C U.S.A.	•
Maryland 21215-0020	be filad within 72 hours aftar daath with tha Maryland nat Hygiana. d other than "natural", or frams 23a or 28a-f show event, the Medical Examiner must be notified at	۵	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: WW		as Decedent of H Yes, specify Cuba ☐ Yes 2 [X] No	Hispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gre	ucation de completed)	16a. Decede	nt's Usual Occup	oation during most of work	kina	16b. Kind of Business	s/Industry
121	within ana.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retire	perated		Liquor	Store
0	should be filad vind Mantal Hygis marked other t	Ö	17. Fether's Neme (First, Middle, Last)		UWII	eu u o		e (First, Middle,	Maiden Surname)	00010
an	id be antal ced o	To Be	Jessie	Holland	Harba	uah	Nelli	e	Louise	Harp
ary	should ind Man imarke umatic	-	19a. Informant's Name/Relationship (7						er, City or Town, State,	
Ž	and 2 salth a n 27 is	1	Linda L. Mose	Daughte	er 112	28 Gree	enmount A	venue, F	lagerstown,	Md. 21740
ře,	s 1 a of Hac othe	- 1	20a. Method of Disposition		Place of Disposi cemetery, crema	tion (Name of	ce)	Date	20c. Location - City or	r Town, State
Ē	Pagas nant of I ant: If its ury or o		1	Removal from State r) F	Rest Hav		-	1-30-06	Hagerstown	, Maryland
Baltimore,	permit, Pagas 1 and 2 should Dapartmant of Haaith and Man important: If teen 27 is marke any Injury or other traumatic. DDCs.		21. Signature of Funeral Service Licen R. Hoel Bru	/					Home, Inc. lagerstown,	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea						Approximate Interval Between
	Physician			P						Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition	. Ineum	Lonia					3 W
	LAdimine		resulting in death)		(or as a conseque	ence ol):				
	sit sed	line.		b. Dement	11d					15 ×
_	and and II-tran	хап	Sequentially list conditions, if env. leading to immediate	Due to	or es a conseque	ence of):				
9	be a sician buria	<u>ea</u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	· Kenal	Fail	m/				IM
x 68760,	artificata be axecuted ling physician and a as tha burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a conseque	ence of):				
õ	ith ca tandii or use	and		d						
0	a daa tha al	Physician/	Part II. Other significant conditions co	entributing to death but not re	sulting in the und	lerlying cause giv	ven in Part I.	23b. Did t	obacco use contribut	e to the cause of death?
д,	that the ned by a datacl							1 🗆 🗅	res 2□ No 3□ F	Probably 40 Unknown
Division of Vital Records, P.O. Bo	The law raquires that the death cartificate be axecuted sta has been signed by the attending physician and page 2 should be deteched for use as the bunal-transit	Completed by							an autopsy 24b. med?	Were autopsy findings available prior to completion of cause of death?
<u>~</u>	Tha ata h paga	5						404	as 2NNo	1 ☐ Yes 2 ☐ No
<u>ita</u>	i lcian: Tha iav cartificata has ractor, paga 2	Be	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only o	ne)	
<u>></u>	Physics this ca	၉	1 Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	3□ DOA Oth	4 X Flursing Ho	ome 5 🗆 Resid	lence 6 Other (Spe	ecify)
5	Attanding Physician: ir daath. ector: Aftar this cartific by tha funaral diractor.	iio iii	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injur Wor	ryet rk? Yes 2 ∐ No	28d. Describe h	low injury occurred	
Division	Hospital or Attanding I 24 hours aftar daath. Funeral Director: Aftar Italy fillad in by tha funar	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, stree ify)		100 20.00	28f. Location (S City or Tow	Street and Number or F m, State)	Bural Route Number,
	To the Hospital or Attanding Physician: Tha lav within 24 hours aftar death. To the Funeral Director: Aftar this cartificata has complataly filled in by the funeral director, page 2	edicai C	29a. Certifier 1X-Certifying Phyone) 1X-Certifying Phyone 1X-Certifying	rsician: To the best of my kn finer: On the basis of exemin and manner stated.	owledge, death c ation end/or inve	occurred at the tin stigation, in my o	me, date and place, ppinion, death occur	and due to the ored at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the compla	₹	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	- s - o	1	m 42			DG	2323		1/26/6	
		1	30. Name end address of person who o	completed cause of death /lts	m 23e) (Tvna. Pr		رءر	3117	12010	
34	1-4+1	- [Khalid Waseem	1126 Opal 0			vn, Maryla	and 2174	10	ļ
	Sta	te	31. Dete filed (Month: Day Year)	32. Registrar's Sign	nature	,	-			
	Registr	ar	MARSO NO 8 KI	JUO A BRECOM	D. April	sale and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 1:20 AM Q4 Ruby Irene HUFF Jan 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dashinatur Booksbord Reedy ahrney Vursing Home.
7. Age In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1□M 20 F 214-09-0135 92 Director March 10 1913 Maryland Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 271s markad other than "natural", or items 23s or 28s-f show other treumatic event, it a Medical Examinal must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Blue Ridge Drive Funerai 21713 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3√2 Widowed 4 □ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F 2 Howard Clayton Keplinger Lona Etta Widdows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 soft Health and tem 27 ls Charles T. Huff - Son RR 5 Box 410 Miffflinburg, Pennsylvania 17844

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Baltimore 20a. Method of Disposition Pages 1 permit. Pages Department of Importent: If it any injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Ringgold Cemetery 1/28/06 Ringgold, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home .415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** - dvanced disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Herson 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ō 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No P.O. be detached the 9 Unknown 9 Unknowed ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate of Vital 1 ☐ Yes 2 与cto Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After Division Hospitel or Attending Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thalid 1126 Opal Court, Hagerstown MD MM Waserin 31. Date filed (Month) Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 ear **Physician** JAN 24 EVELYN VIRGINIA HARDING 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG 2 1914 5. Social Security Number 220-16-1177 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 91 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heelih and Mental Hygiens. Important: If time 27 is marked other than "natural; or liems 23a or 28a-f show any injury or other traumatic event, the Modical Examinat main be notified at 1 Yes 2 No Director MONTGOMERY GERMANTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17301 BLACKROCK ROAD 20874 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Heelth and Mental Hitant: If Item 27 is marked other. WILLIAM CLEVELAND HUNGERFORD LILLIAN PEDDICORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRY HALLETT / NIECE 7250 MOSS LA., WARRENTON, VA 20187 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CARMEL CEMET. 1/30/06 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State Donation 5 Other (Specify) SUNSHINE, MD 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 6 HOURS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificete has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death NIA 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 72 months? Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2. No 1 Yes 1 Yes 2 No To the Hospitei or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident М 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check ont one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE ROAD # ZOS ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 6 2006

32. Redistrar's Signature

		1 - For Stata Registrar	State of Ivia	irytana /	Certifica			-	Reg. N2 0 0	6 (3536	
Physicia	an	1. Decedent's Name (First, Middle, Last) Michael Hiagins					Month Day Year			3. Time of Death		
/Medic Examin	al	4a. Facility Name (If not institution, give	4b. Ci	4b. City, Town, or Location of Deat			4c. County of Death		15.00			
36	•			inglo		Balt	imor	e				
Funeral Director		5. Social Security Number 6. Se 216-64-8121 Usual Residence of Decedent	7. Age	(In yrs. last l	Yrs. If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV - 1	7, Year) 5, 1955	Countr	ce (State or Foreigr YLAND	
/land		10a. State 10b. County		10c. City, To	own or Location					100	d. Inside City Limits	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f show eny Injury or other traumatic event, the Modical Examiner must be notified at once.	ctor	MD DORCHE:	STER		CAMBRID	GE					Yes 2□No	
	Funeral Director	10e. Street and Number	10f. Zip Code					10g. Citizen of W		y?		
	eral	113 SOMMERSET AVI	12. Was Decedent E	ver in U.S.	13. Was Dec	21613		pecify Yes or No		SA - Americar	ı Indian.	
	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			pecify Cubai	spanic Origin? (S n, Mexican, Puert Specify:	o Rican, etc.)	Black	WHIT	c.	
	Completed	15. Decedent's Edi (Specify only highest grad	16	16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry				
	du	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) ACCOUNTANT						MEDICAL				
	0	17. Father's Name (First, Middle, Last)			ACCOU	TEML	18. Mother's Nar	ne (First, Middle	Maiden Sumame			
	To B	G. HERMAN HIGGINS, SR. MARGAR						SARET JO	RET JONES			
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									ode)	
		G. HERMAN HIGGINS 20a. Method of Disposition	S, JK./BKU	20b. Place	of Disposition (A	lame of		Date Date	, MD 216		n. State	
		1 Nourial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,)	ceme	tery, crematory o	r other place TERY	2/6/	2006	NEAVIT	T, MA	RYLAND	
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS. HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601										
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
		trimediate Cause (Final disease or condition resulting in death) An eumonía 7 days										
Examiner	/	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Myelocytic Levicemia Due to (or as a consequence of): C. Due to (or as a consequence of):									1.0	
rificate be executed g physicien and as the burial-transit	Jer											
	Examiner											
be ex sicien burial	al E											
- m -	edical		d									
eath cert attendin I for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							23d. Date of delivery			
To the Hospitel or Attending Physician: The law requires that the death cewithin 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attendincompletely filled in by the funeral director, page 2 should be detached for use	yslcl	in the past 12 months? 1							Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?			
	ed by							10	1 Yes 2 No 3 Probably 4 Munknown			
	Completed								24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
	Con								200 No 1	eath? Yes 2	□No	
	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)										
	. To	27. Manner of Death	28a. Date of Injun (Month, Day		Outpatient 3 ::	28c. Injury Work	4 U Nursing F		dence 6 Other			
	atlo	Natural 5 Pending 2 Accident investigation		Year)	Injury M		í? ∕es 2 □No					
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatic City or							n (Street and Number or Rural Route Number, Town, State)			
	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To th Within To th compl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Monti								(Month, Da	ay, Year)	
		* allen Jenn, MD 19762 1/30/2							20	00		
-5-		30. Name and address of person who c	completed cause of de	Sath (Item 23a	a) (Type, Print)	Sti	Balti	m ove,	WD 3	120	7)	
Sta Registr		31. Date filed Menty, Day, 202 2006	e. Registra	r's Signature								

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

						Cer	tificate of	Death		Reg. No.	6 0353	1
	Discolation		1. Decedent's Neme (First, Middle, Les	st)					2. Date of D Month	eath Day	3. Time of De	eath
	Physici /Medic		Charles	Irving					Jan.	21 20	006 2:45	PM
j	Examin		4a. Facility Name (If not institution, give						, or Location of Dea			
			St. Thomas Mor						ville		ce Georges	
	Funeral		5. Social Security Number 6. S	KIM OFF	(In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, D Dec • 6	irth Day, Year)	9. Birthplace (State or Fi	oreign
	Director	1	229-18-0225 Usual Residence of Decedent	79)	110.			рес. 6	,1920	Virginia	
	land		10a. State 10b. County		10c. City, To	own or Loc	ation				10d. Inside City L	
	Mary	ō	District of Co	lumbia	Wash	ingt	on				1 □Xxes 21	□No
	28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Country?	
	3a or	Ē	3805 Jay Stree	t. N.W.	Apt.	3	20019	9		U.S.	Α.	
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	- Ap	13. W	as Decedent of H	lispanic Origin	? (Specify Yes or N uerto Rican, etc.)	lo- 14. Rac	e - American Indian,	
0	after or ite	Ē	Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐XN	О		Tes, specify Cuba		ruerto nicari, etc.)		ck, White, etc. v: Black	
8	ours i	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		'	Li tes ZIAINO	эрвыну.		Specify	DIACK	
2-0	should be filed within 72 hours after death with the Maryland Ind Mental bygiene. In marked other than "natural", or items 23e or 28e-f show It marked other than "natural", or items 23e or 28e-f show Itematic event, The Madical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de com <i>pleted)</i>	10	6a. Decedi (Give k	ent's Usual Occup ind of work done O NOT use retired	ation during most of	f working	16b. Kind of Bu	usiness/Industry	
Maryland 21215-0020	vithin nen nen	ם	Elementary/Secondary (0-12)	College (1-4or 5				a)			ialable	
2	lled v tygie her ti		12th. 17. Father's Name (First, Middle, Last)		1_U	navı	alable	18 Mother's	Name (First, Middl			
ä	ntal h	Be							vialable		-,	
$\tilde{\Xi}$	hould d Me mark maric	ဥ	Unavailable 19a. Informant's Name/Relationship (Type Print)	1	Oh Mailine	Address (Street		or Rural Route Num		State Zin Code)	
⊠	d2sth antrans7isi		Belinda Ann Jac									
ē,	Heal Heal Hem 2		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		2006		City or Town, State	
altimore,	ages ant of t: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐				etory or other pla e Park			Riverda	ale, Maryl	and
₫	nit. F artm ortan Injur		21. Signatur of Funeral Service Licen		KIVC		Name and Addre				neral Home	
ä	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		Valab liti	2. 11		2.0	21 Coo	ecia 7		_	C.20011	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	Dications that caused	the death. D	o not ente	r the mode of dyir	ng, such as ce	rdiac or respiratory	arrest,	Approximate	
	Physician		shock, or heart failure. List only								Interval Betwee Onset and Dea	ath
2	/Medical		Immediate Cause (Final disease or condition	a CHRO	NLC	04	sthur	Tive	1011102	Dixas	1 YEAR	12
	Examiner		resulting in death)		Due to (or es				(0,0)			
	sit ad	/Medical Examiner	7-25	b							1	
	ertificate be executed ling physician and e as the burial-transit	хаш	Sequentially list conditions, if any, leading to immediate	1	Due to (or as	a consequ	ence of):					
68760,	be exician buria	a E	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
687	ficate physis the	edic	resulting in death) Last		Due to (or as	a consequ	ence of):					
X	in 5 6		•	d								
. Bo	death c e attenc ed for us	Icla	Part II. Other significent conditions of	ontributing to death bu	t not resulting	a in the un	derlying cause giv	en in Part I.	23b. Die	d tobacco use cor	ntribute to the cause of d	deeth?
<u>о</u>	at the death ce by the attendi stached for us	Physician		3		-	, ,		1	Yes 2□ No	3 Probably 4 □ Un	ıknown
	ss tha	by F							-		T	
Records,	v require been sij should l								24a. We	s en autopsy formed?	24b. Were autopsy find evailable prior to	
ပ္ပ	e law re has be ge 2 sh	Completed									completion of caus of deeth?	se
=		POC I							1□	Yes 2☐No	1 ☐ Yes 2 ☐ No	o
Vital	Physician: The I r this certificate ha	Be	25. Was case referred to medical examiner?	114-1			011		Death (Check only	one)		
7	£ = =	ဥ	1 Yes 2 No		nt 2 ER/			4 Li Nursi	ng Home 5 ☐ Res	sidence 6 Other		
ŭ	ding P th. After t	ë E	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 281	o. Time of Injury	28c. Injur Wor M 1 □	rk? Yes 2∐No		now injury occur	eu	- 11
<u>s</u>	ttend death stor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ry - At home	farm stre		103 2 2 110		(Street end Numb	er or Rural Route Number	<i></i>
Division of	or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	, 10,111, 0110	ot, lactory, omeo		City or To	own, Stete)		
	spital			ysicien: To the best o								
	n 24 h	edical	(Check only 2 Medical Exan	niner: On the basis of and manner ste	examination ted.	and/or inv	estigation, in my o	pinion, deeth	occurred at the time	e, date and place,	and due to the cause(s)	_
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After t completely filled in by the funeral	Σ	29b. Signature and title of certifier	1	1		29c. Licens		-		d (Month, Dey, Year)	
	n)		VanCler	Levo	14	~	D	018	52	Janua	m 23,20	06
	9)6		30. Neme and address of person who					12	e hos	It asi 11	e MD 2078	3/
			31. Date filed (Month, Day, Year)	25 Penistra			eersbo	my 10	1 1114	V 30.		•
	Sta Registr	8.	JAN 2 6 2006	See Heyssia	r's Signature	W						

	ľ	1 - For State Registrar	State o	f Marylan		artment <i>rtificate</i>		ealth and N Death	Mental Hy	giene Reg. No.	00	6	03538	
Dharin		1. Decedent's Name (First, Middl	e, Last)						2. Date of De Month	eath Day		Year	3. Time of Death	_
Physicia /Medic		Ellis Hu	nphries	Iacon	ie .				January				6:15P [™]	
Examin	er	4a. Facility Name (If not institution	-					Location of Death	1	4c.	County o	f Death	_	
		Collingswood						Spring	T = =			gomer		_
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)		Count		
Director		578.03.3192 Usual Residence of Decedent		0/		L			Oct.18	, 191	18	Virg	ginia	
/land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10	Od. Inside City Limits	-
the Marylar 28a-f ahow notiling at	to	Maryland Mont	gomery	0	lney								1⊠Yes 2□No	
or 28s	Director	10e. Street and Number				10f. Zip C	Code			10g. Citi	zen of W	hat Count	try?	_
		17810 Shotley	Bridge P1	ace		20	832			U.	S.A.			
er death w Itams 23a	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.	Was Decede	ent of Hi	spanic Origin? (Si	pecify Yes or No	0-		- America		_
or It		1 Never Married 2 Mar	ned 1 ☐ Yes If Yes, Giv	2⊠ No ⁄e		1 ☐ Yes 2		Specify:			Specify:	Whi		
hour:	d by	3 ☑ Widowed 4 ☐ Divorced		ates:	1 40 - 5		_							
n 72 "nal	lete	(Specify only highe	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	done d	lurina most of wor.	king	16b. Kii	nd of Bus	iness/Ind	lustry	1
withi lene. then	Completed	Elementary/Secondary (0-12)	College (1	I-4or 5+)		ntrepr				Dry	Cle	anin	g Services	
filed Hyginether	Be C	17. Father's Name (First, Middle,	Last)			rerept	CITC	18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)		-
id be lental Ked ic ev	To B	John Thomas	Frazier					Bessie	Lee S	Sea1				
shou ind M ind M	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numb	er, City o	Town, S	itate, Zip	Code)	
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, intransportant: if item 27 is marked other than "natural; or ital any Injury oceans traumatic event, its Medical Examinal once.		Pamela Patrice	Jackson/D	aughter	17810	Shot	lev.	Bridge 1	Place (Olnev	. Ma	rvla	nd 20832	
Item 1		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name	e of		Date	20c. Lo	cation - C	ity or To	wn, State	-
Page In the Page		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S						tory 1/2	24/2006	Bre	ntwo	od, Ma	aryland	
mit. partn ports y inju		21. Signature of Funeral Service	Licensee	-	22	2. Name and	Addres	s of Facility	AT HOME				-	
8858		Noncy A	. Vercen	Tu	11	800 N	ew E	DI FÚNEF ampshire	Ave. S	ilve	r Sp	ring	. MD 20904	
		23a. Part1. Enter thase, or shock, or failure. List	complications that conly one cause on e	aused the deatl							CH HAZER	100	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Sepsi										Onset and Death	
/Medical		resulting in death)	d	(or as a conseq	uence of):		-							1
Examiner		Sequentially list conditions.	b. Pneum											
D II	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to ((or as a conseq	uence of):									
ta be executed ysician and a burial-transit	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	or as a consequ	uonoo of):									_
be ex			Due to	(OI as a consequ	derice or).									
ata	dical		d							_				+
ath certific ittending p or use as:	lan/Med	IF FEMALE:	23c. If yes, out	come of pregna	incv						22d Data	of dalam		
eath atten for u	Iclan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 Feta	I death 3	Ectopic pre				4	Mont	of deliver	ry Day Year	
that the dead by the	hysle	1 □ Yes 2 🔼 No 9 □ Unknown	9□ Unkno		50	_ Other (spec	City/							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	٥	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying car	use give	en in Part I.	23e. Did	tobacco u	se contrit	oute to the	e cause of death?	
ures n sign	d by								10	Yes 2	□No 3	3 🗌 Proba	ably 4 🛣 Unknown	
w requir	ompleted								24a. Was	s an	24b. W	ere autor	osy findings available	-
The lav ate has page 2	E								auto	opsy ormed?	pr de	ior to comeath?	npletion of cause of	
	ပ	25. Was case referred to medica	ı					26. Place of Dea	1 Yes		11	Yes	2 L No	_
	To B	examiner? 1 ☐ Yes 2X No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA	Othe	\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ome 5 Res		3 🗆 Other	(Specify		-
g Phya er this aral di		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o		c. Injury Work		28d. Describe				/	-
ath. r: Afr	atlo	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	3	in, Day Toai,	Injury	М		res 2 □ No						
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place	of Injury - At ho	ome, farm, st	reet, factory,	office		28f. Location (r or Rural	Route Number,	-
rs aft ra aft ai Di ed in				3 , 5,00011					2, 3. 70	, 51410				
dospi t hou uner uner	edical	29a. Certifier 1 ☑ Certifyii (Check only 2 ☐ Medical	ng Physician: To the Examiner: On the b	best of my kno	wledge, deat	h occurred at	t the tim	e, date and place	, and due to the	cause(s)	and man	ner as sta	ated.	
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funaral di	Med	one)	and mani	ner stated.										-
With To	-	29b. Signature and title of certifie	' () ()	1				number					Day, Year)	
3		M		1			H-5	1280		Janua	ry 2	20, 2	006	
		30. Name and address of person						ivo Dani-	Томис -			. +	MD 2007/	
1 60 1 61		Anushiravan Da 31. Date filed (Month, Day, Year,		ordi, Mi legistrar's Signa		19 Exe	cut	ive rark	rerrac	e, G6	: mar	ıcown	L, MD 208/4	-
Sta Registr		JAN 2	2006	Sugar A	S. As	CACA .								

			For State Registrar	State of Ma	aryland /			nt of He te of D			ental F	Hygier	- 0 10 0	035	39
			Decedent's Name (First, Middle, Last)							2. Date of	Death		3. Time of	Death
8 .	Physicia		AUBREY GREGORY JO	NES							Month Janu	ary [22, 2006	6:50	аМ
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location of	of Death			4c. County of Death		
			Laurel Regional H	ospital			La	ure1					Prince Ge	orge's	
	Funeral		5. Social Security Number 6. Se	7. Ag	(In yrs. last l		If Unde	r 1 Year Days	If Under		8. Date of (Month,	Birth Day, Yea	9. Birth	place (State o	r Foreign
	Director		215-09-1330 Usual Residence of Decedent	2 IVI 2 I	90	Yrs.				((Month,	27,	1915 Mary	land	
	land		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside Ci	ty Limits
	Mary f ah	o	Maryland Prince Ge	orgola	Green	hal+								1 📉 Yes	2 □No
	r 28a	Director	10e. Street and Number	orge s	Green	DETC	10f. Z	p Code				10g.	Citizen of What Cou	ntry?	
	h with		4 Empire Place				20	770				U	.S.A.		
	eme :	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Nas Dece	dent of His	spanic Ori	gin? (Spec	offy Yes or	No-	14. Race - Ameri Black, White		
9	or it		1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give		.	1 □ Yes	1	Specify:		ilouit, oto.		Cassifu		
9500-61212	be filed within 72 hours after death with the Maryland ald Hygiene. All the Hygiene do that than "natural", or Iteme 23a or 28a-f ahow dothar than "natural", or Iteme 23a or 28a-f ahow evant, Ira Middical Esantia at minat ke inclilled at evant.	d by	3 X Widowed 4 □ Divorced	Year or Dates:		- D	11-11-					100	WII	ite	
ည်	in 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of w DO NOT I	ial Occupa ork done di ise retired)	tion uring mos	t of workin	g	166	Kind of Business/Ir	idustry	
7	iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5	,	Sales		,				T	nsurance		
2	Hyg Hyg otha	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Mic		len Sumame)		
<u>a</u>	should be ad Menta marked imatic ev	To B	Charles H. Jones						Anni	e L.	Love	less			
Maryland	ss 1 and 2 should to if Health and Ment Item 27 is marked other traumatice	1	19a. Informant's Name/Relationship (7)				•						y or Town, State, Zi		
	and ealth m 27 nar tr		Susan Motley - Da	ighter					e, Gr				land 2077		
9	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ F	lemoval from State	20b. Place ceme	of Dispo tery, cren	sition (Na natory or	me of other place		Da			Location - City or T	own, State	
Baltimore,	F 40 7		4 □ Donation 5 □ Other (Specify)		Ammer					1/26/			ltsville,		and
ä	permit. Depart Import any inj		21. Signature if Firm al Service Leans	98	1279								ral Home, ille, MD		
elle.			23a. Part1. Enter the disease, or compl	ications that caused	the death. D								IIIe, m	Approximat	Α
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	10.			30 0. 0,g	, 525			, 4,,,,,,		Interval Bet Onset and I	ween
)-	Physician /Medical		disease or condition resulting in death)	Pneumon:	ia a consequenc									7 days	
	Examiner			Due 10 (01 as	a consequenc	01).									
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e of):									
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Š	e exe ian a urial-	EX	resulting in death) Last	Due to (or as	a consequenc	e of):									
2/PU	death certificate be executed e attending physician and id for use as the burial-transit	dicai		j											4
×	ding p	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				201-			=			
X O D	that the death certifii ed by the attending r detached for use as	ian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic p	regnancy					23d. Date of delive Month		rear
j.	che the	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	unio or death	3	J Other (3	pocity/				_			
J.	requires that sen signed by hould be deta	by Pr	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the u	nderlying	cause give	n in Part I.		23e. E	id tobacc	o use contribute to	he cause of d	leath?
Hecords	w requires to been signer should be	p p	Acute Renal Failu	ce; Parki	nsonism	1					1	☐ Yes	2 X No 3 □ Pro	bably 4 ⊡l	Jnknown
ပ္သ		Completed									24a. V		24b. Were aut	opsy findings	available
	0 - 0	E									p	utopsy erform <u>e</u> d s 2 🔯	? death?	ompletion of c	ause of
VITAI	ystcian: Th	Bec	25. Was case referred to medical examiner?		Property.				26. Place	of Death					
o 	Ø 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10	1 ☐ Yes 2 🔀 No	lospital: 1 🕅 Inpatie	nt 2 ER/	Dutpatien	t 3 🗆 D	OA Othe	[□] 4 □ Nu	irsing Hom	e 5 🗆 F	lesidence	6 ☐Other (Speci	fy)	
_	0 9 9	:uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury		28c. Injury Work			Bd. Descr	be how in	njury occurred		
DIVISION	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	- Di - (1)			М		es 2 🗌		nt 1	(0)			
\geq	or A after Direc in by	Certification:	4 Homicide determined	28e. Place of Injuding, et	iry - At nome, c. (Specify)	farm, str	eet, facto	y, office		2		Town, St	and Number or Rui ate)	ai Houte Num	ber,
_	A Hospital or Attending 24 hours after death. Funeral Director: After etely filled in by the funeral process.		29a. Certifier 1K Certifying Phy	sician: To the best	of my knowled	ga dissit	persino	t at the time	e data hi	d place in	id due to	the earns	es sancero bne fall	teted	
	of 4 m s	Medicai	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination a	and/or in	vestigatio	n, in my op	inion, dea	th occurre	d at the tir	ne, date	and place, and due	o the cause(s)
	To the Within 2 To the complet	Ň	29b. Signature and title 1 certifier	1	_	_	29	c. License	number			29d.	Date signed (Month,	Day, Year)	
	211		> / Milel	alle	exh	6		D2409	3			Jar	nuary 22,	2006	
, /	2/11/0		30. Name and address of person who co									1			
<u> </u>	J 11-1		Mark Parkhurst, N		Sarvis	Aven	ue,	River	dale	, Mar	y1an	d 207	737		
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registr	ar's Signature	hom									

			for State Registrar	State of Marylar		artment of H		Mental Hygier	Title 1	03540
	4 8 M. W	8.	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
4	Physici /Medi	càl	MYRTLE V.	JACKSON		the Other Transport			2, 2006	1931 M
100	Examir	ier	4a. Facility Name (If not institution, give s			•	r Location of Deat		c. County of Death	
		. 19.5	Shady Grove Adv 5. Social Security Number 6. Sex		14	ROO If Under 1 Year	ckville		MONTGON	
13	Funeral Director			M 2 1 77		Months Days	Hours Min.	(Month, Day, Yea		ace (State or Foreign
-	4 8		Usual Residence of Decedent	, ,				July 4,1	.928 Ma	aryland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			10	Od. Inside City Limits
	Mary	ō	MD Montgo	omery	.Ga:	ithersb	urq		-	1 ☐ Yes 2 No
	28a	Director	10e. Street and Number	-		10f. Zip Code		10g. C	Citizen of What Coun	trv?
	3 with	ā	40 Prairie F	Rose Court		21	0878		U.S.A.	•
	within 72 hours after death with the Maryland ene. than 'natural', or Itams 23e or 28e-f ehow he Medical Examenat must be notified at	Funeral		12. Was Decedent Ever in U	J.S. 13. V			Specify Yes or No-	14. Race - America	an Indian,
(0	rita	Τ̈́	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	l I	Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, White, e	etc.
80	urs a	þ	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates:	1	Yes X No	Specify:		Specify: Bla	ck
Õ	2 ho	Completed	15. Decedent's Educ	cation		ent's Usual Occup		16b.	Kind of Business/Ind	lustry
218	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	during most of wo d)	rking		
21	d wit	E O	Zionionaly, obserioury (5 12)	3 yrs		Comput	ter Tec	h	F.D.A.	
פ	oth oth	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Maide	en Sumame)	
<u>a</u>	Aenta Aenta rked ric e	ToE	Maurice K. F	Fisher			D	ora E. Si	.mms	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any flury or other treumatic avent, the Mudical Expiritment must be notified at once.		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Number, City	or Town, State, Zip	Code) 20070
	alth a		Pamela R. Johns	son (Daug)	40 I	Prairie	Rose C	ourt, Gai	thersbur	rg,MD°/°
Baltimore,	s 1 a f He f He othe	1 9	20a. Method of Disposition		Place of Dispos	sition (Name of natory or other place	201	Date 20c.	Location - City or To	wn, State
9	a = 1 5 €		t Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	n Cemete	1	7-06 Di	ckerson,	MD
≣	artin artin	1 1	21 Signed 1 of Funeral Service Loopie		22	. Name and Addres	ss of Facility C N	OWDEN FUN	EDAI HON	TE TO A
B	Per Grant Proposition	1 1	Consag-Kil	Mound				., Rockvi		
-	1		23a. Part1. Enter the disease, or complic	cations that caused the deal					TIC, HD	Approximate
			shock, or heaft failure. List only one Immediate Cause (Final	e cause on each line.	1	- 1/ Cl	1001	-16		Interval Between Onset and Death
Fig.	Physician /Medical		disease or condition resulting in death)	PULM	ONA	XY EM	1806	02		IDAY
	Examiner			Due to (or as a consec	(uence of):					
		-	Sequentially list conditions, if any leading to immediate	Due to (or as a consec	mence of):					
	ted sit	nin.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	233 13 (3. 43 4 33) 133	14 01100 017.					
_	cate be executed physicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	mence ot).					
8760,	be e icien buria	E E			, = 3.7.					
87	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	d.							
9 ×	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancv					
. Box	ath certif attending for use as	lan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	il death 3 🗌	Ectopic pregnancy			23d. Date of deliver Month	y Day Year
o	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	ieath 5	Other (specify)				,
0	that the hed by detac	Ph	Part II. Other significant conditions cont	tributing to death but not res	ulting in the un	dorhina causa anu	on in Part I	23a Did tobacco	use contribute to the	a source of death?
Records,	signe b be			induiting to additing that had	anny in the un	darrying causa give	on in route.	,	\	ibly 4 Unknown
0	w requir been si should	Completed						T Tes	2 № No 3 ☐ Proba	ioly 4 Olikilowii
ec	e law has t	nple						24a. Was an autopsy	prior to corr	sy findings available
	The l	Ö						performed? 1 ☐ Yes 2 ☑ N	death?	2 No
Vita	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	,			26. Place of Dea	ath (Check only one)		
\leq	S S D	မ	1 ☐ Yes 2 ☑ No Ho	ospital: Inpatient 2	ER/Outpatient	3□ DOA Othe	er: 4 🗌 Nursing H	lome 5 Residence	6 ☐Other (Specify,)
Division of	ding Ph h. After th funerat		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	y at k?	28d. Describe how inj	ury occurred	
000	endi sath. or: A he fu	ati	2 ☐ Accident investigation				Yes 2 □ No			
ž	er de	ti ti	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Street a City or Town, Sta		Route Number,
0	spital or Attensours after deations after deations in Director:	Certification:		,	,,			0.07 0.000, 0.00	,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	icien: To the best of my kno	wledge, death	occurred at the tim	ne, date and place	a, and due to the cause(s) and manner as sta	ited.
	vithin 24 h	Medical	one)	er: On the basis of examina and manner stated.	and or inv	estigation, in my of	pinion, death occu	arred at the time, date at	iu piace, and due to	me cause(s)
	To T	Σ	29b. Signature and title of certifier			29c. License	e number	29d. D	ate signed (Month, E	Day, Year)
}	10		MI MID			63	263	1/	23/20	06
	(0)		30. Name and address of person who con	npleted cause of death (Iter	п 23а) (Туре, Я	rint)		- 1 D	115 -	-0-
			HAKIM MORSLI	9901 Me	licalo	enter [one,	1/ Rockville	MDZ	08 80
1000	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		and I				
740	Registr	ar	JAN 60 AU	TUU PINGMEN .	N. 10 10 10 10 10 10 10 10 10 10 10 10 10					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20, 2006 4:58P. **Physician** JANUARY John Phillip Johnson, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year NOV 18, 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 1987 Yrs. 18 213~17-7714 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Yes 2 No Salisbury Directo MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21801 137 Second Street by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) n/a n/a 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Debra Purnell John Phillip Johnson, Sr. 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 137 Second Street, Salisbury, MD 21801 Debra Purnell/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Green Acres Mem Park 1/28/2006 Salisbury, MD permit. Page Department of Important: If any injury or ance. 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lewis N. Watson Funeral Home alsono Idlance Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ P/Outpatient 3 ☐ DOA 6 ☐Other (Specify) 1 XYes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: After 5 Pending investigation is effer de. 1 Natural 1 TYes 630 06 2 Accident 281. Location (Street and Number or Rufal Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 € Homicide filled in within 24 hours e To the Funerel L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number e and title of certifier 29b. Signa O.C.M.E. JANUARY 21, 2006 completed cause of death (Item 23a) (Type, Print) 30. Name and address of 32. Redistrar's Signature PENN STREET BALTIMORE, MARYLAND 21201 6 State

Registrar

			State of Maryland / Department of Health and M Certificate of Death		iene _{eg.} No. 0 0 6	03542
			Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h Day Year	3. Time of Death
Н	Physicia /Medica		5 AMURI W. KOSTER	/	23 06	
1	Examine		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		4c. County of Dea	
			BITYWOODS OF ANNAPOLIS 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) 1. Months Deven Min.		AACO	
E	Funeral Director		5. Social Security Number 6. Sex 15/2 M 2 F 86 Yrs. Social Security Number 6. Sex 15/2 M 2 F 86 Yrs. Social Security Number 15/2 Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Bii	thplace (State or Foreign ountry)
	p ,		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aryle ahov	_				1 ☐ Yes 2 ☒ No
	he M	ect	MD: AA CO ANNA POLIS 10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	with o	ᄒ	7101 Bayfront Drive, #213 21403		USA	
	heath	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Am	
020	urs a	2	Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Never Married 1 Never	Rican, etc.)	Specify:	VHLTE
21215-0020	2 hor	Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing	16b. Kind of Business	/Industry
218	within 7 iene. than "n				211/1	
	filed with Hygiene. ther than	5	17. Esthar's Name (First Middle Last) 18. Mother's Name 18. Mother's Name	OFFICER	Milder Sumama)	ARIJ
pu	tal H d oth aven		17. Patiet's Natile (1784, Wildele, 2237)			
Maryland	2 should be on and Mentals marked raumatic a	ှ		Louise S		Zin Code)
Mai	d 2 sh th end 7 is n traun	Ì				
o,	i and Healt em 2	-	Cherie Koster/Wife 71()1 Bayfront Drive, 20a. Method of Disposition (Name of Disposition (Nam	#213, A	Innapolis, 20c. Location - City o	MD 21403 r Town, State
ō	nt of nt of it it	1	1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State	Jan 24		100
Baltimore,	rtant njury	1	4 □ Donation 5 □ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee	2006	Baltimore	e, MD
Ва	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra pnce.		495 Gov. ritchie Hw	y, Sever	rna Park, I	MD 21146
à	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cashock, or heart failure. List only one cause on each line.	or respiratory ar	est,	Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition a METHSTATIC RENAL CAR	CINON	MA	5 Ve
1	Examiner		resulting in death) Due to (or as a consequence of):			
	ים פ	Examiner				
	cete be executed physician end s the burief-transit	хаш	Sequentially list conditions, Due to (or as a consequence of):			
68760,	cete be execui physician end the buriet-trai	ie Li	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to the british of seaso or injury conditions)			1
387	physis the	dicai	that initiated events Due to (or as a consequence of): resulting in death) Last			
_	certifi ding Ise at	Š	d			
Box	death certifi e ettending ed for use as	clai	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco use contribu	te to the cause of death?
P.O.	the ache	by Physiclan/M		1 🗆 1	. /	Probably 4 Unknown
	w requires that the been signed by the should be detache	Y P	NONE			
Records,				24a. Was a		. Were autopsy findings available prior to
ပ္ထ	law reas bee	plet				completion of cause of death?
æ	The law ete has page 2	Completed		101	65 2 NO	1 ☐ Yes 2 ☐ No
ita	ilcien: The certificete rector, pag	Bec	25. Was case referred to medical examiner?	1		
5	S S D	2	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 ☐ Nursing Ho		ence 6 □Other (Sp	ecify)
n o	ng Ph fter th ineral		1 Works 5 Pending (Month, Day Year) Injury Work?	28d. Describe h	ow injury occurred	
sio	eath. or: A	cati	2 Accident investigation M T Tes 2 No	28f Location (9	Street and Number or	Rural Route Number.
Division of Vital	or Att	튀	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	m, State)	Taria Troute Transco,
	To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical Certification:	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and pancer stated.	and due to the o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	thin 2 the mple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	1 :	29d. Date signed (Mo	nth, Day, Year)
	F.₹ F.8	1/2		2	1/23/	26
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1/23/0	
			RONALD (SROKA IND 1684 VIIIA & GREEN	ROFTO	N, Md.	21114
	Sta	te	31. Date filed (Month, Day, Year) 32. Redistrar's Signature		1	
	Registra	ar	JAN 2 4 2006 Marie A Could			

			For State Registrar	State of Marylan	-	artment of H		and Me		iene eg. Nó:	06	03543
			Hegistrar Decedent's Name (First, Middle, Last)					2.	Date of Dear	th		3. Time of Death
	Physici	an	George Paul Ku	rtz				ار. ا	Month San	2 ^{Day} 2	0 0 6	3:10p ^M
	/Medic		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location o			4c. County		
1	Examin	ei	Genesis ElderC			S	ever	na Pa	ark	An	ne A	Arundel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under :		Date of Birth (Month, Day			place (State or Foreign
	Director		214-44-3534	M 2□F 58	Yrs.	Months Days	Hours		ug. 29	, 1947	000	MD
	p.		Usual Residence of Decedent	100 00	y, Town or Lo	ti						10d. Inside City Limits
	anylar	_	MD Anne Arr		y, Town or Lo	Severna	Park					1 ☐ Yes 2X No
	88-1	octo		ander						0g. Citizen of	Mhat Cou	
	with th	吉	10e. Street and Number	n Dood		10f. Zip Code	21146			og. Okizen of	US.	·
	a 23	rai	444 Arundel Beach	12. Was Decedent Ever in U	S 13 1			nin? (Specif	v Yas or No-	14. Ra		can Indian,
21215-0036	in 72 hours after death with the Maryland "naturel", or itema 23e or 28e-f ahow ladical Examine must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Types 2 No If Yes, Give Year or Dates: Viet		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No		n, Puerto Rio	an, etc.)		ck, White,	
9	72 ho	ted	15. Decedent's Educ (Specify only highest grade	cation		dent's Usual Occupa		t of working		16b. Kind of B		,
21	⊆ 2	P P	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)				[rans	-
		Completed		3		Captair					rnati	onal
Maryland	ild be filed lental Hyg kad otha ilc avant,	Be	17. Father's Name (First, Middle, Last)						R. Be	Maiden Sumai Proman	me)	
χ	should nd Men marka umatic	10	Sidney Kurtz	0.1	401 14.75	ng Address (Street					State 7i	n Code)
Na Na	12 a 7	1 1	19a. Informant's Name/Relationship (Type Karen Diane Kurtz			Arundel						
	1 an Heel Heel ther		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	1	Dat	9	20c. Location		
Ď	0 0		12⊠ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	-	matory or other place ans cemet		Jan.		Crown	svill	e, MD
Baltimore,			4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License						006			
Ba	permit. Departr Importe any inji		& Thomas El	416N	4	95 Gov. 1	ritch	ie Hwy	, Seve	erna Pa	rk fu rk, M	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.						rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ANOXIC	Er	VCEPH/	460	PAT	744			WEEKS
	/Medical Examiner		resulting in death)	Due to (or as a consec		10.						1.15000
	Examine:	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		ARRE	521					WEEKS
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	CORONA		ARTER	20	NIC	EASE	-		YEARS
	be executed sicien and burial-transit	xan	that initiated events cresulting in death) Last	Due to (or as a consec		717-101		1013	CASE			7-711
8760,	be e sicier buria	icai										
687	ficate physics the	edic		•								
Вох	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	el death 3	□Ectopic pregnancy □ Other (specify)	,				ate of deliv	rery Day Year
P.O.	at the de by the (tached	hysi	9 Unknown	9□ Unknown								
	es that igned b	by P	Part II. Other significant conditions con		sulting in the u	inderlying cause giv	en in Part I	1.	23e. Did to	bacco use cor	tribute to	the cause of death?
Ď	w require been sig should b		DIABETES M	IELLITUS,	TYPE	2			1 U Y	es 2 No	3 ☐ Pro	bably 4 Unknown
Vital Records,	aw re as bee 2 sho	Completed							24a. Was a		Were aut	opsy findings available ompletion of cause of
æ	The lay	E							perfor	med?	death?	
ital		Bec	25. Was case referred to medical		***************************************		26. Place	e of Death (Check only o	ne)		
>	nysicii nis cer direci	ToE	examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	er: 4 Nu	ursing Home	9 5 ☐ Resid	ence 6 □Ot	her (Speci	ify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur Wor	y at k?	28	d. Describe h	ow injury occu	rred	
Sio	Mtandil death. ctor: A y the fu	cati	2 Accident investigation				Yes 2					
Division	al or Attands after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, office		28	f. Location (S City or Tow		iber or Hui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai (sician: To the best of my knoner: On the basis of examinating and manner stated.								
	vithin o tha	Me	29b. Signature and title of certifier	\ a =		29c. Licens	e number			29d. Date sign	ed (Month	, Day, Year)
	- s ⊢ ō		1 Bri Ca	Dollne	mo	D	3/12	6	1	JANU.	424	23 2006
7			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type.	, Print)	J. 1 3				1 (-5, 2000
			-	CACE, MD.	900.	5 KIL	BR	1025	RD, B	termo	RE. 1	23, 2006 nn 21236
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign		,			-		7	
	Regist	rar	JAN 2 4 200	6 Person	K A	mark 1						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryla Registrar	-	artment of H		nd Mental Hy	giene Reg. No. 006	03544
	ger Si Dhaasa		Decedent's Name (First, Middle, Last)				2. Date of De Month	aath Day Year	3. Time of Death
- 2	Physici /Medic	al	Flora Lee KARB	ELING			Januar		
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Bethe		f Death	4c. County of De	
			Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year		24 Hrs. 8. Date of Bir	rth 9 B	intholace (State or Foreign
Н	Funeral Director		325-26-7699 1 1 M 2 T 7		Months Days	Hours	Min. Sept. 2	1929 II	linois
8	- Ar - Ar		Usual Residence of Decedent						Land Levid Obelience
	inylan show		10a. State 10b. County 10c. C	city, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-fa	5	Maryland Montgomery	Potoma				10g. Citizen of What 0	21
	with th	直	10e. Street and Number 9116 Paddock Lane		10f. Zip Code 208.5	54		United St	
	ns 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in	U.S. 13.			gin? (Specify Yes or No , Puerto Rican, etc.)		rerican Indian,
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Items 23s or 28s-f show event, I're Medical Examinat must be notified at	by Fun	Armed Forces? 1 Never Married 27 Married 1 Yes, 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 1 No	Specify:	, Puerto Rican, etc.)	Black, Wh	
Ö	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	of working	16b. Kind of Busines	s/Industry
218	within 7 ene. then "n	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	d)	or working		
21	e filed within at Hygiene. I other than "	Completed	2	Но	memaker	10 Matha	de Name (First Middle	Own Home	
Maryland 21215-0036	be fill	Be	17. Father's Name (First, Middle, Last) Louis Brown			18. Mothe	r's Name (First, Middle Esther Dan		
2	2 should be and Mental Is marked o	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	na Address (Street	and Numbe		ber, City or Town, State	, Zip Code)
S	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other traumatic ence.		Emanuel Karbeling, Husband				Potomac, M		
ē,	Heal Hem		Edd: William of Broposition	Place of Disponent	osition (Name of matory or other place	ne)	Date	20c. Location - City	or Town, State
OE.	Pages of the Pages		t∑Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ju				s 01/24/06	Olney, MD	
Baltimore,	Departm Departm Importer any inju		21. Signature of Funeral Service Licensine	T_{c}^{2}	2. Name and Addre	ss of Facilit	w Funeral	Home	
m	88 1 2 8			2.5	54 Carrol	1 St	NW. Washi	ington, DC	20012
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dyin	ng, such as	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition						
	/Medical Examiner		resulting in death) Due to (or as a conse	equence of):					
l sa		-	Sequentially list conditions, b. Due to (or as a constitution)	equence of):					
	uted 1 ansit	Examine	Sequentially list conditions, if any, leading to immediate author. Enter Underlying Cause (Disease or injury that initiated events						
ó	exec an an	Exa	resulting in death) Last C. Due to (or as a consi	equence of):					
8760,	icate be executed physician and s the burial-transit	cai	d						
9	death certificate be executed e attending physician and id for use as the burial-transit	Med	IF FEMALE:			-			is were
Вох	eath certific attending pl	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg	tal death 3	□Ectopic pregnancy □ Other (specify)	у		23d. Date of o Month	Day Year
o.	at the de by the a tached i	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	death 5	Other (specify)		Licensia and a second		
<u>α</u>	g g g		Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause giv	ven in Part I	. 23e. Did	tobacco use contribute	to the cause of death?
rds	puires n sign	d by	Acute Renal Failure				10	Yes 2 No 3	Probably 4 Unknown
Records,	s been si	Completed					24a. Wa		autopsy findings available o completion of cause of
æ	The tay sete has page 2	E						formed? death	es 2 No
Vital	rtifice	Be C	25. Was case referred to medical			26. Place	of Death (Check only	**	
of V	Physiclen: r this certific ral director,	10 E	Landard Control of the Control of th	☐ ER/Outpatie	ent 3 DOA Oth	ner: 4□ Nu		sidence 6 Other (S	pecify)
	ding Ph h. After th funeral		27. Manner of Death 1 √∑ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo			how injury occurred	
sio	eat or:	cati	2 Accident investigation	h		Yes 2		(Street and Number or	Pural Poute Number
Division	7 2 7 2	Certification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	cify)	тевт, тастогу, отнов			own, State)	naiar noble Wallion,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	dicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, dea nation and/or is	th occurred at the ti nvestigation, in my o	ime, date ar opinion, dea	nd place, and due to the oth occurred at the time	e cause(s) and manner a, date and place, and c	as stated. lue to the cause(s)
	within To the Compl	₩ W	29b. Signature and title of certifier		29c. Licens	se number	, 1	29d. Due signed (Mo	onth, Day, Year)
-	3		1 hagais	Dann	0.0	()	1+	1/22/1	56
-	J		30. Name and address of person who completed cause of death (I Marjorie F. Dannis, M.D., 8600	em 23a) (Type) Old G	Print) eorgetown	Road	, Bethesda	, MD 20814	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 4 2006 32. Registrar's Signary	nature A	garde				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [State
Registrar Amend Item #5 Per INF C852 2990 (September 1) . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 22, 2006 7:11 P M Krebs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill of Bethesda Bethesda Montgomery 5. Social Security 0655 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 K F Director 212-14-0665 85 June 16, 1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at Director 1 TYes 2 ₹ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2709 Emmet Road 20902 death USA Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be tiled within 72 hours after Department of Health and Mental Hygiene. I important: I fem 27 is marked other than "netural; or its any injury or other traumatic event, the Madical Examina once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No White If Yes, Give Year or Dates: Specify: Ď Specify: 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ernest Frederick Lang Clara I. Tarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce C. Groves/ Daughter 6221 Cobblers Green Court, Gainesville, VA 20155 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State January 27, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Marylan 21. Signatur 1 Filheral Service Licenses Francis Addes Coliffus Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure To Thrive /Medical Due to (or as a consequence of): Examiner Skin Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death Year 5 Other (specify) be detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident М 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H51280 January 23, 2006 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, M.D. 13219 Executive Park Terrace, Germantown, MD 20874

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

32. Aegistrar's Signature

2006

AEM 06-00709 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend unpend its #1,23a,27, pen/F,855,5/5/06 TT

Amenditer#1,per/F,855,5/24/06 TT

Continue of Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amenditer#1,per/F,855,5/24/06 TT

Continue of Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nicole Kimuilakani For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nicole Kimvilakani Nicole Kimuilakani **Physician** Nicole Ekutsu Kimvilakani January 28, 2006 2:10 P " /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 37 215-02-6929 Director 7/27/1968 Zaire Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow the Medical Examiner must be notified at MD Silver Spring Montgomery 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2949 Hewitt Avenue #393 20906 USA Ітата 23а Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2X No tf Yes, Give Year or Dates: filed within 72 hours efter 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black φ 3 ☐ Widowed 4 X Divorced "natural" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filed with Deportment of Health end Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic avent, the Monte. Disabled 5+ None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Kanienda ဂ <u>Marie J.Ekutsu</u> 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Ekutsu Kimvilakani/ 310 Ethan Allen Ave. Takoma Park, Md20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Chesapeake Crem. 2/4/06 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Lice PHILIP ORTINALDI FUNERAL SERVICE, P.A. 21. Signature of 9241 Columbia Blvd.Silver Spring Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Complications of motor neuron disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit pue Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificete 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 □X es 2 □ No 2 SER/Outpatient 3 □ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNaturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number January 29, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z M.D. Creenser 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

02

2006

32. Segistrar's Signature

BURS

			For State Registrar	State of Maryla	•	artment of rtificate of				giene Rag. No.	06	03547
1	Physici		1. Decedent's Name (First, Middle, Last) Carl E. Klink						2. Date of De Month	Day	Year 06	3. Time of Death
)	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location	of Death		A.	unty of Death	
		, c <u>.</u>		SPITAL			MBER				LLEGI	
	Funeral		5. Social Security Number 6. Sex 187 24 3479	M 2□F 7. Age (In y	rs. last birthday, Yrs.	Months Days		Min.	8. Date of Bir (Month, Da 4-22-1	y, Year) 925	PA	place (State or Foreign intry)
	Director		Usual Residence of Decedent						-, 22 1	<i></i>		
	how		10a. State 10b. County		City, Town or L							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-fs	octo	PA Somerset	. Co.	leyersda	10f, Zip Code				10g. Citizer	n of What Cou	
	with th	Dir	90A Laurel Falls	Rd.			5552			US		,
96	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependrent of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itame 23a or 28a-f show my injury or other traumaltc event, the Medical Examinat Instituted at Ances.	y Funeral Director	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in Armed Forces? 1XXYes 2 □ No if Yes, Give	1 U.S. 13.	Was Decedent of If Yes, specify Cu	ban, Mexica	n, Puerto r	cify Yes or No Rican, etc.)		Race - Amer Black, White pecify: Whi	, etc.
21215-0036	nin 72 hours In "naturel" Medical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: sation completed) College (1-4or 5+)	(Give	dent's Usual Occu a kind of work done DO NOT use retir	e during mos	st of workir	ng		of Business/Ir	
212	giene giene er the	E OC	8			river	1	1. 11	(F:> 0.6:1-11-		cing Co	•
Maryland	should be file nd Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Clyde	Klink			18. Moth		(First, Middle e Mil.			
Mary	12 shou h and M 7 is mar traumat		19a. Informant's Name/Relationship (Typ. Lottie Klink			ing Address (Stree Laurel F						
	of Health are item 27 is		20a. Method of Disposition		b. Place of Disp	osition (Name of ematory or other pi	= T		ate		tion - City or T	
ē	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		(Wilhel		L-21-	2006	Meyer	sdale,	PA
Baltimore,	permit. I Depirtm Importai any inju		21. Signature of Funeral Service License	1/1 0003	374 3	2. Name and Add	ress of Facil	Pri Vever	ce Fund	eral H	Home, I	nc.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comblishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	other the mode of dy	ail bstv	MA MA	2		<u>teota</u>	Approximate Interval Between Onset and Death
8760,	ate be executed obysicien and the burial-transit	Ilcal Exan	that initiated events resulting in death) Last	Due to (or as acon	sequence of):		NUC.		1	9		
P.O. Box 68	The law requires thet the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnan	псу			236	d. Date of deli	very Day Year
	s thet ned b e deta	by Pt	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause	given in Part	1.	23e. Did	tobacco use	contribute to	the cause of death?
rds	w require been sig should b			Dinbe	tes	mell	utz	5	14	Yes 2	No 3∏Pro	obably 4 Unknown
II Reco	The law resate has be page 2 sho	Completed							24a. Was auto perf 1 Yes		prior to death?	topsy findings available completion of cause of 2 No
Vita Vita	rector	Be	25. Was case referred to medical examiner?	lospital:	- 5500	-7222	\thon		(Check only		TOther (See	.6.1
ō	Phys r this sral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	ALL SOL DON	4 () (-	me 5 Res 28d. Describe			лу)
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, s	M 1	☐Yes 2☐			(Street and own, State)	Number or Ru	ral Route Number,
_	e Hospital 24 hours a Eunaral I etely filled	edical Ce	29a. Certifier 12 Certifying Phys. (Check only one) 2 Madical Examin	sician: To the best of my nar: On the basis of exar and manner stated.	knowledge, dea nination and/or i	ath occurred at the nvestigation, in my	time, date a y opinion, de	nd place, ath occurr	and due to the red at the time	cause(s) ar , date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of certifier	0			nse number			29d. Date	signed (Monti	n, Day, Year)
			> John 16	Manns	Maj). D-	175	-26		yann	117 1	1,2006
10	414		30. Name and address of person who co				berlan	d, MI	2150)2		
-3	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S		, June						

			1 - State of Maryland State of Maryland		artment of H			ene 2006	03548
	Physic		1. Decedent's Name <i>(First, Middle, Last)</i>	ν	OGAN		2. Date of Death Month	18, 2006	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)			Location of Death	January	4c. County of De	
		М	5 Featherwood Court, Apt. 11 5. Social Security Number 6. Sex 7. Age (In yrs. las			Spring		Montg	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. B 1922 Rus	rthplace (State or Foreign Country) SSTA
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or La	cation				10d. toside City Limits
	h the Maryland r 28a-f ahow notified at	ctor			r Spring				1 ☐ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number		10f. Zip Code			. Citizen of What C	•
	death ms 23	neral	5 Featherwood Court, Apt. 11 11. Marital Status 12. Was Decedent Ever in U.S.	13. \	2090			nited Sta	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow among injury or other traumatic event, it a Medical Examination to the traumatic event, it a Medical Examination other traumatic event, it a Medical Examination.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give X Year or Dates:			spanic Origin? (Spent) n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
15-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	lent's Usual Occupa	ation furing most of worki)	ina 16	b. Kind of Busines:	s/Industry
212	d withir jiene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired, ineer)		Governmer	1+
nd	be filed tal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Last)	3			(First, Middle, Ma		
Maryland 21215-0036	should ad Men marke matic	은	I sya Kogan 19a. Informant's Name/Relationship (Type, Print)	10h Maika	- 14		Rosenvin		
ĭ ⊠a	and 2 shalth ar alth ar 27 is er trau			55 F1:	r Drive,	nd Number or Rura Roslyn, Ņ	NY 11576	ity or Town, State,	Zip Code)
Baltimore,	If item		A Desire & Description of Distribution State	a of Dispos atery, crem	sition (Name of natory or other place			Location - City or	
ıltir	nit. Pa artmen ortant: injury injury		' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Fur and Service Licensee	-	ardens	01/20		ockville,	MD
Ba	Deparent Important in any ir	(V) 7		70	orchinsky 54 Carrol	°Hebrew F 1 St., NW	uneral Ho	ome	20012
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying	, such as cardiac o	r respiratory arrest	JUILS DU	Approximate Interval Between
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death) a. Non-Find kins Due to (or as a consequent	Lym	phoma				Onset and Death 6 Months
	Examiner		Sequentially list conditions h	pe orj:					
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Cle acc or injury that initiated events	ce of):					
oʻ	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	ce of):					
8760,	cate be physici the bu	dical	d.					- 1	
Вох 6	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date of de	ivery
0. B	ne deat the atte	Physiclan/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
ري ح	es that the de igned by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause giver	n in Part I.	23e. Did tobac	o use contribute to	the cause of death?
ord	w require been sig should b						1 🗆 Yes	2 No 3 ₽	obably 4 Unknown
Records,	ela has je 2	Completed					24a. Was an autopsy performed	? prior to death?	itopsy findings available completion of cause of
	(G LT	BeC	25. Was case referred to medical examiner?			26. Place of Death	1 Yes 2 K (Check only one)	No 1 ☐ Yes	2□ No
5	this aldii	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3 DOA Other	4 Nursing Hom			cify)
LOI!	tending leath. tor: After the funer	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury Work? M 1 🗆 Yo	es 2 No	8d. Describe how i	ijury occurred	
DIVISION	all or Aug s after de al Directo	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	io ine nospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death and/or inve	occurred at the time	, date and place, a nion, death occurre	nd due to the cause d at the time, date	o(s) and manner as and place, and due	stated. to the cause(s)
F	To the comp	Me	29b. Signature and title of cartifler		29c. License			Date signed (Montl	
	3	-	30. Name and address of person who completed cause of death (Item 23a	.) (T. =		6108	> 1.	th 19,	2006
			Paul Thambi, M.D., 9707 Med			r., #300,	Rockvill	e, MD 2	0850
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 0 2006 32. Registrar's Signature	Spa	de .				

State

31. Date fifed (Month, Day, Year)

TERRY

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JODRIE, M.D.

Registrar

29c. License number

D40324

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735

29d. Date signed (Month, Dey, Year)

JANUARY 20, 2006

			1 - State	State of M	farylan			nt of H		Men	ıtal Hy	/giene	4 U U	6	0355	0
			1. Decedent's Name (First, Middle,	Last)							Date of D	eath			3. Time of Deat	h
	Physici		Josefa	${f L}$	ovo						Month anua:	ry 2	ž1, ž	2006	4:25P	М
	/Medic Examin		4a. Facility Name (If not institution,					, Town, or	Location of Deal				. County o	Death		
_			TIONI OTTOBE			Fores Road Past birthday)	9	ilve	r Spri	ngs	Date of Bi		ontgo		Y ace (State or For	eian
	Funeral Director			1□M 25€F		83 Yrs.	Months		Hours Min		Month, D	ay, Year)	192	Count	icarag	
			Usual Residence of Decedent			0.3				IMC	11 (11	20,	1 .7 4			
	ehow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	ld. Inside City Lin 1 X Yes 2 □	
	8e-1	Director		gomery	Wh	eaton	1.04.7	. 0 4				10= C	tizen of Wi			
3	with the	Dire	10e. Street and Number					ip Code	2						ry :	
-	s 1 and 2 should be filed within 72 hours after death with the Maryland if the ath and Mental Hygiene. If the art is marked other then "naturel", or items 23s or 28s-f show other traumatic event, its Medical Examinar must be notified at	Funeral	11505 Elkin S	12. Was Deceden	nt Ever in U	.S. 13.		2090 edent of Hi	spanic Origin? (\$	Specify	Yes or N	L	arag		ın Indian,	
	riter d	Fun	1 Never Married 2 Narrie	Armed Forces d 1 Yes 2 5	?		If Yes, sp	ecify Cuba	n, Mexican, Puei	to Rica	an, etc.)			White, e		
Ś	er's a	þ	3 Widowed 4 Divorced	If Yes, Give 1 Year or Dates	-			2□ No	Specify: quan				Specify:	His	panic	
5	72 ho	Completed	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Us	ual Occupa	ation during most of wo	rking		16b. K	(ind of Bus	iness/Ind	ustry	
4	n n n	E E	Elementary/Secondary (0-12)	College (1-4o	r 5+)							Dri	vate	2		
1	Hygie ther t		7 17. Father's Name (First, Middle, La	ast)		НОГ	пем	aker	18. Mother's Na	me (Fi	rst, Middle					
	ontal l	o Be	Catarino Acos						Ramono							
<u>, </u>	2 should be filed within and Mental Hygiene. is marked other then aumatic event, I.a.Ms	ို	19a. Informant's Name/Relationshi						and Number or F							
	od 2 27 is r trau		Daisy Reyes/ D	aughter		1150	5 El	kin	Street	# 8	3 Wh	eato	on, N	lary	lanđ ^{og}	<i>J</i> 2
ָ בּ	of Height		20a. Method of Disposition			Place of Dispo	sition (Na matory or	ame of other place	∍ Janı	Date		20c. L	ocation - C	ity or Tov	vn, State	
É ,	Page nent c		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		。 Ge	neral	Cer	nete	P 57	006	_	1	icar	agua		
<u> </u>	permit. Pages 1 and 2 Depertment of Heatth a Important: if Item 27 is eny injury or other tra		21. Signature of Furieral Service Li	censee					s of Facility Mu	ırr	av F	une:	ral	Home	- 480	4
3	80559		1 Thellip	Bell Sr		G	eor	gia <i>l</i>	Avenue	NW	Was	hin	gton	, DO	20011	_
F	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure/ List of Immediate Cause (Final disease or condition resulting in death)		ver	Failu		ode or dylni	g, such as cardia	IC OF TH	spiratory	arrest,			Approximate Interval Between Onset and Death	ı
	Examiner		Convention by the secretation of	b Se	ntic	Shoc	k									
•	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consec	quence of):										
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. As	spira	tion	Pne	umon:	ia							
Š	cien a		l l l l l l l l l l l l l l l l l l l	Due to (or a	is a consec	querice or).										
200	physi s the	dicai		d												
. DOZ .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: Attent this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	⊒Ectopic ⊒ Other (:	pregnancy specify)					23d. Date Mont		ry Day Year	
Ľ	that t ed by deter		Part II. Dther significant condition	s contributing to death	but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did	tobacco	use contri	oute to th	e cause of death	?
2	uires sign	d by	Status post	CVA - He	emipa	aresia	ì				1 🗆	Yes 2	No €	B ☐ Proba	ably 4 Unkn	own
5	w req	Completed	Malnutritio					_			24a. Wa		24b. W	ere autop	sy findings avail	able
ב	The la te has age 2	mo					<u> </u>				auto peri 1 Yes	opsy formed? 2 🟋 No	de	ior to con ath? ⊒Yes	npletion of cause 2□ No	of
<u> </u>	an: Titica tor, p	a	Dementia / 25. Was case referred to medical	Coagulo	patny	<i>I</i>			26. Place of De	eath (C			9			
_	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 XInpa	itient 2□] ER/Outpatie	nt 3 🗆 🛭	Othe Othe	er: 4 🗆 Nursing	Home	5 🗆 Res	sidence	6 ☐Othe	(Specify)	
5	ng Pt		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of in (Month, L	njury Day Year)	28b. Time o		28c. Injun Work		28d	. Describe	how inju	iry occurre	d		
200	tendi leath. tor: A the tu	cati	2 Accident investigation in Suicide 6 Could no	ation of the			M		Yes 2 □ No	004	Location	/Ctroot o	and Alivertic		Courte Atumbas	
2	il or At atter d Direct	Certification:	4 Homicide determin	289. Flace OI	Injury - At h etc. <i>(Speci</i>	iome, farm, st	reet, facto	ory, office		281.		own, Stat		r or Hura	Route Number,	
	ne Hospita 24 hours ne Funers detely fille	edical C		Physician: To the be xaminer: On the basis and manner	of examina											
	Withir Comp	Me	29b. Signature and title of certifier				2	9c. License	e number			29d. Da	ate signed	(Month, I	Day, Year)	
	ye			*				478	67			Jan	uary	22,	2006	
	(i)		30. Name and address of person w	ne completed cause o	f death (Ite	m 23a) (Type,	, Print)				Roc	kvi	110	Mar	y120852	
	U		31. Date filed (Month, Day, Year)	Dr. 32 Regis	Zunic strar's Sign	ga 4	701	Rand	dolph F	loa	d``Šŭ	ite	216		1 - 4114	
	Sta		JAN 2.5 2000	Ke _ J		2019										

		1- For State of Maryland / Department /	artment of Health and N rtificate of Death		2111b 113551
		Decedent's Name (First, Middle, Last)	Timodic of Bedin	2. Date of Death	h 3. Time of Death
	sicia	Tohn Waster Tarana T		Month	Day Year
	edica mine		4b. City, Town, or Location of Death	January	22 2006 2:16P ^M 4c. County of Death
LAU		7754 Burnside Road	_		
Fune	ral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Landover If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's
Direct		579-36-7132 1⊠M 2□F 74 Yrs.	Months Days Hours Min.	(Month, Day,	
D		Usual Residence of Decedent		June 18	, 1931 Wash., DC
rylar	i .	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
a Ma		Maryland Prince George's	Landover		11 Yes 2 □ No
th the	1	Maryland Prince George's 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
th wi	-	7754 Burnside Road	20785		United States
dea ems	6		Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	United States 14. Race - American Indian,
after a	ű	1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No If Yes, Give		Hican, etc.)	Black, White, etc.
OO3	i		1 ☐ Yes 2√∑ No Specify:		Specify: Black
d 21215-0036 Ilied within 72 hours after death with the Maryland Hygione. the than "natural", or items 23a or 28a-f ehow int, the Medical Examination and the continuous possible of the most	40	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Education (Give life. II)	tent's Usual Occupation kind of work done during most of work	ina 1	6b. Kind of Business/Industry
	2	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,,,g	
ygie t	6	12th	Security		Government
Ind be fill tal H d ot	a	u 17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, M.	aiden Sumame)
Va Ould Men Men arke	F			Esther S	Sockwell
Maryland 21215-0036 at 2 should be filed within 72 hours aft thit and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exemple			g Address (Street and Number or Rura		
and and ealth m 27 m 2		Debra Lyons - Daughter 333	7 Ely Place, S.E.	Wash., I	OC 20019
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than * natural*, or items 23a or 28a-1 ehow any injury or othar traumatic evant, it a Madical Examinar must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispo	sition (Name of patory or other place)	Date 20	Oc. Location - City or Town, State
Pag ment ant:		`4 □Donation 5 □Other (Specify) Marvland	Veterans Cem. 1/30	0/06	Cheltenham, MD
saff spart sport vy inj	OUCE.				ineral Home
m 99 = 9	ä	John L. Shewart III	4001 Benning Rd.		
		23a. Part1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac o	r respiratory arres	t, Approximate
Physicia	ın	Immediate Cause (Final	Tie CArdiovA	cold in	Interval Between Onset and Death
/Medic:		disease of condition resulting in death) a. If the School Constitution and the consequence of the consequen	110 0111017	cogar	Tican Distant
Examine	er	Sequentially list conditions			
₽ ≓	Examiner	Sequentially list conditions, if any, lacting to immediate cause. Enter Underlying			
ocute nd trans	an	Cause (Disease or injury that initiated events c.			
O, B exe ian a urial-	Ĕ	resulting in death) Last Due to (or as a consequence of):			
68 / 6U, ificate be executed physician and as the burial-transit	Cal	d			
	Medi				
COLOS, P.O. BOX O wrequires that the death certifit been signed by the attending I should be detached for use as	clan/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery
dea ed fo	200	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
at the by the stack the	hysi				
ords, F.O. requires that the een signed by th hould be detache	by P		derlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
cords, wrequirest been signe				1 ☐ Yes	2 No 3 Probably 4 Donknown
taw re	ompleted			24a. Was an	24b. Were autopsy findings available
The taw te has b	E O			autopsy performe	d? prior to completion of cause of death?
cian: Terrificat	O	25. Was case referred to medical	00 Diagram - 4 Danie	1 Yes 2	No 1 ☐ Yes 2 ☐ No
ysici ysici s cer	OB	examiner? 1 Yes 2 No Hospital: 1 Dispetient 3 DED/Outsetient	26. Place of Death 3 DOA Other: 4 Nursing Hom		ce 6
g Phy er this	l ii	- Day and - Day		8d. Describe how	
r Attanding for death. iractor: After	atio	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,
Atta Atta or deg	ific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree		8f. Location (Stree	et and Number or Rural Route Number,
din l	Certification;	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, S	State)
To the Hospital or Attanding Physician: The law within 24 hours after death. Yo the Funaral Director: After this certificate has completely filled in by the tuneral director, page 2.			occurred at the time, date and place, a	nd due to the caus	se(s) and manner as stated
ne Ho ne Fu	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or inventor and manner stated.	estigation, in my opinion, death occurre	d at the time, date	and place, and due to the cause(s)
To the within To the Somp	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
(n)		forwarder /host in as	140053 92		
13/		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)	J.	11 may 15, wo6
Jg c	2	SALVANDOS Sylvester, 3001 Hosp	ital Drive C	Levert	Many 1006
s	tate	31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		7	1
Regis	trar	JAN 2 6 2006 Bleeve			

			1 - For State Registrar	State of	f Marylar			nt of H			lental Hy	giene Reg. No		6	03552
			1. Decedent's Name (First, Middle	a, Last)							2. Date of De	ath Dav		Voor	3. Time of Death
	Physici /Medic		Margaret	Lui	kart						January			Year)6	5:00P M
	Examin		4a. Facility Name (If not institution	n, give street and num	nber)		4b. Cit	y, Town, o	Location	of Death		4c.	County	of Death	
			Springhouse at					ethes		-0411			Mont	tgom	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		Month	er 1 Year s Days	Hours Hours	Min.	8. Date of Bin (Month, Da	y, Year)		9. Birth Cou	place (State or Foreign intry)
	Director		105-01-2271 Usual Residence of Decedent		96	113.			<u> </u>		August	19,	1909		Ohio
	land ow		10a. State 10b. County		10c. Ci	ty, Town or L	ocation								10d. Inside City Limits
	Man 9-1-8h	ţċ	Md. Mont	tgomery	Ве	thesda									1 X Yes 2 □ No
	or 28.	lrec	10e. Street and Number				10f. 2	Zip Code				10g. Cit	izen of W	Vhat Cou	intry?
	23a unt b	Funeral Director	5101 Ridgefield	d Road #3	06				816				.S.A.		
	tems	nue	11. Marital Status	12. Was Dece Armed For	rces?	I.S. 13.	Was Dec	edent of Hoecify Cuba	ispanic O In, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-		e - Ameri k, White,	ican Indian, , etc.
36	hours after death with the Maryland turel', or Items 23a or 28e-f show at Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	0		1 🗆 Yes	2 🖾 No	Specify	<i>r</i> :			Specify.	Whi	te
3	hour	edt		t's Education	165.	16a. Dece	dent's Us	sual Occup	ation			16b. K	ind of Bu		
3	in 72 in "ne Medit	Completed	(Specify only highest Elementary/Secondary (0-12)	st grade completed)	-4or 5+\	(Give	kind of	vork done d use retired	durina mo	st of worki	ng				,
7.17	d with giene ar the	E O	Elementary/Secondary (0*12)	College (1 5-f	-401 347	Reme	dial	Educ	atio	n Tut	or	Edu	ıcat:	ion	
9	al Hy I other	Be (17. Father's Name (First, Middle,	Last)							(First, Middle,			e)	
<u>X</u>	should be filed within 72 hours after death with the Marylan nd Mental Hyglene marked other then "neturel", or Items 23a or 28e-f show umatic event, the Madical Examiner must be notified at	2	James Benjamin							cille		yder			
Maryland 21215-0036	l 2 sh and ls m reum		19a. Informant's Name/Relations				•				il Route Number				p Code)
o o	1 and Health em 27 ther t		Clark Luikart 20a. Method of Disposition	/ Son	20b. I	4U8 Place of Disp			LVa.		Island,				own, State
٥	nt of nr of		1 ☐ Burial 2 🖾 Cremation		State	cemetery, cre ropoli	-			T 1	0.2006			•	Virginia
Baltimore,	artme orten		* 4 ☐ Donation 5 ☐ Other (S		riet				ss of Facil	lity De	Vol Fun	eral	Hom	ie	721621124
n	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic express.		View Story	Sell		1					., N.W.				20007
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that co	aused the deal	th. Do not en	ter the m	ode of dyin	g, such as	s cardiac o	or respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		nemic C										Onset and Death
	/Medical		resulting in death)	W	or as a consec										
	Examiner		Sequentially list conditions,	D	al Fib		ion								1 Week
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	or as a consec		D.								7 77
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Corc	nary A	rtery quence of):	Dise	ase							7 Years
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٥	tificat ng phy as th	0.00													
ROX	death certifii e attending p id for use as	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnation]Ectopic	pregnancy					23d. Date Mon		ery Day Year
		scl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregna 9□ Unkno	ant at time of o	leath 5	Other (specify)					IVIOI	1011	Day Toal
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Hecords	siclen: The law certificate has b irector, page 2 sl	Completed									autop	rmed?	p	rior to co eath?	empletion of cause of
Vital	iffication, pa	e C	25. Was case referred to medical						26 Plac	e of Death	1 ☐ Yes	2 ⊠ No	1	☐ Yes	2□ No
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0000	tending leath. lor: After the funer	atlo	2 ☐ Accident investig	gation			М		Yes 2						
DIVISION	or Att	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	innd 200. Flace	of Injury - At h ng, etc. <i>(Speci</i> i	ome, farm, st fy)	reet, fact	ory, office		2	28f. Location (S City or Tox			er or Rur	al Route Number,
_	ne Hospitel or Attending P n 24 hours after death. ne Funerel Director: After toletely filled in by the funera		29a. Certifier to Certifyin	ng Physician: To the	hest of my key	nwladna dast	h occurr	ad at the tim	ne date a	nd place :	and due to the	Cause/e\	and mar	nner as s	stated
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	To the within 2 To the Complet	Me	29b. Signature and title of genifie	Ma			2	9c. License	number			29d. Dat	e signed	(Month,	Day, Year)
	10		I (all V (Ulas				MD005	2247			Janu	uary	19,	2006
	1		30. Name and address of person								1		1 0		
			Collin D. Culle						Ul Be	ethes	da, Mar	ylan	id 20	1814	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2	0 2006	egistrar's Signa	J. A	osse	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 January 9:55 a. M Maloney Edward Bernard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Cambridge 1101 Glasgow St. if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 212-18-4350 87 March 16, 1918 Director Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itams 23a or 28a-f show 1 XYes 2 □ No Dorchester Cambridge MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21613 1101 Glasgow St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) airplane mfg. manufacturing engineer 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Vane Michael Malonev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2: Department of Health at Important: If item 27 Is any injury or other trau 20b. Place of Disposition (Name of cametery, crematory or other place)

Date

Date

20c. Location - City or Town, State Michael Maloney son 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □Other (Specify) 1/28/06 Oxford, MD Oxford Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Ker 700 Locust St., Cambridge, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): PheymoniA Examiner Mation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) or in july that initiated events resulting in death) Last s a consequence of Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 certificate 1 Yes 2 □ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier W ho completed cause of death (Item 23a) (Type, Print) address of pe MD 21613 Bramble 100 Registrat's Signature Date filed (Month, Day 2006 State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** EVELYN S. MOORE 16,2006 January 12:05 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince George 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🗹 F Yrs. 266-30-8872 May 5,1919 Director Albany, Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or itema 23a or 28a-f show to Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MDPrince George Brandywine Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13226 Brandywine Road 20613 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after di tal Hygiene. d other then "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Nursing Aide Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fit. Health and Mental H tem 27 is marked of Effan Stafford Mattie Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is Charles J. Davis/Son 13226 Brandywine Road Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 01/21/2006 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. Mary E. Hedgman M0137 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print). 12070 OC) LINE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4 2006

			1 = For State Registrar	State of	Maryla				leaith a Death	and M	lental Hy	giene Reg. No.	0	06	035	155
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8	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-1 show ha Maryleal Exemirer mast be redilled at	1 by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dat	tes:		I ☐ Yes	2K No	Specify:				Speci	ity: BLA	.CK	
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au	ld be ental ked o	To Be	WILLIAM H. MC					-			CINTYRE		suma	m <i>e)</i>		
Maryland 21215-0036	should and Men a marke umatic	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	a Address	(Street a	nd Number	r or Rura	l Route Numbe	r City or	Towa	State Zin	Code	
ž	1 and 2 the Health ar tem 27 is		PHYLLIS L. MCK	OY/DAUGHTE	R	6309	MORO	CCO S	STREET	r ca	PITOL H	EIGH	TS,	MARYL	AND 2	0743
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Department of Health and Mental Hygene. any injury or other traumatic avant, the Marical Examiner man be retiliated an once.		20a. Method of Disposition	2 Domount from C		Place of Dispos cemetery, crem	sition (Nan	ne of ther place	9)	D	ate	20c. Loc	ation	- City or Tox	vn, State	
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4			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on ear	used the deat ch line.										Approximat Interval Bet	ween
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o	at the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9□Unknow	nt at time of d n	eath 5□	Other (spe	ecify)					ivit	Jilli L	Jay 1	ваг
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=	in Life	Certification;	4 Homicide determi	ned building	, etc. (Specif)	ome, farm, stre V)	et, factory,	office		2	Bf. Location (St City or Town	reet and i n, State)	Vumb	er or Rural i	Poute Numi	ber,
i	Hospital 4 hours a Funeral [tely filled		29a. Certifier 1 Certifying	g Physician: To the be	est of my kno	wledge, death	occurred a	t the time	, date and	place, ar	nd due to the ca	alise(s) ai	nd m	anner ac etal	lad	
	e de e	edical	(Check only 2 Medical E	Examiner: On the basi and manner	S OI GRAIIIIII	tion and/or inve	stigation,	in my opi	nion, death	occurre	d at the time, d	ate and p	ace,	and due to t	he cause(s)	į
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の 生	Stat	0	K. MICHAEL F 31. Date liled (Month, Day, Year)		3001 istrar's Signa		ıı Dr	TAG (Jneve	rтy,	mary⊥a	nd	207	785		
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			For State Registrar	State of Maryland		artment of H			giene Reg. No.	006	03556
			Decedent's Name (First, Middle,					2. Date of De		V	3. Time of Death
	Physici		Wilmer	Melgare	es			JANUARY	Day 2.1	. 2006	8:17A. M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	CILICIAN		ounty of Dear	
	E Xamin	ei	7001 WEST PARK	DRIVE		HYATTSV	TLLE		PR.	INCE G	FORGES
	Funeral			Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Bir	hplace (State or Foreign
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			Usual Residence of Decedent								
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	end ealth m 27			gares/Brother		1124		Pate Date		ey Pal ation - City or	
0	OF HE		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	C6	metery, cren	sition (Name of natory or other plac	ce)				
Ē	Parit Parit		4 □Donation Other (Spe	10/1172	nicipa	al Cemet	tery1/31	/06	omay	yague.	la, Honduras
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta important: If Item 27 is marked any injury of other traumatic ev		21. Signature of Inneral Service in	enole.	P1	HTLTP Adde	.ŘÍÑÄLDI umbia Bl	FUNER	RAL S	SERVIO Sprin	CE, P.A. ng, Md20910
			23a. Part1. Enter the disease, or co shock, or heaft failure. List or	implications that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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Вох	death certific e attending p od for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		Tetania prossana			23	3d. Date of de	,
m	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year
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s, P	s that	y P	Part II. Other significant condition	contributing to death but not resu	iting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
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Division of Vital Record	> 0 0	Completed						24a. Was	an	24b. Were at	utopsy findings available
Re	has 96.2	Ę.							rmed?	death?	completion of cause of
G	icien: Th certificete rector, peg	ပိ	25. Was case referred to medical				OS Blace of Deep	1 Yes	- N. C	1 0 Yes	: 2□ No
₹		00	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ 6	ED/Outpation	. all poor Oth	26. Place of Deal			Violetor (Co.	ot CCENE
o	Phys ral di	<u>유</u>	Yes 2 No 27. Manner of Death		R/Outpatien 28b. Time of			ome 5 Resident			CHYDUEINE
o	Attending or death.	Fig	1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 ⊠No	subject	was	stabb	ed and cut
S	deat deat ctor: / the	Ca	3 ☐ Suicide 6 ☐ Could no	be 380 Blace of lower At ho	me farm str	LA		28t. Location (Street and	Number or R	ural Route Number,
$\stackrel{>}{\sim}$	or A after Direction by	Certification;	4 Homicide determin	building, etc. (Specify	- 10-	L. Dark		City or Too	wn, State)	7001	nest Park Dri
_	Hospital		29a. Certifier 1 Certifying	Physician: To the best of my know	viedne death			rogation	ille	mD	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only one) 2 Medical Ex	aminer: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my o	ppinion, death occur	red at the time,	date and p	place, and due	to the cause(s)
	To the within 2 To the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Moni	h, Day, Year)
	F ₹ 5		/s / / /	miss							
	2			/		0.C.	M.E.		ANUA	RY 22,	2000
			30. Name and address of person w	-	23a) (Type,		N STREET 1	RAT.TTMOE	E M	ΔΡΥΤ.ΔΝΊ	21201
			21 Date filed (Month Day Year)	M () Registrar's Signat	ING	TIT LIMIN	A STUDEL 1	PETITION	للا وت	TILL TILL	21201
	Sta Registr		31. Date filed (Month, Day, Year)	2006 Registrar's Signar	40	ME					
	riegisti	aı		1	-/						

			1 - For State Registrar	State of Maryla		artment rtificate			nd Me		iene)6	03557
	.1. jj2 ag		Decedent's Name (First, Middle, La.	st)					2	Date of Deat	th		3. Time of Death
	Physic /Medi		Burnell Mance							Jan.	Day	Year 2006	4:28 p ^M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of I	Death	U all •	4c. Coun	ty of Death	
		ŷ.	Shady Grove Ad	lventist Hos	pital	- F	Rock	vill.	<u> </u>		Mon	taom	erv
	Funeral Director			□M 2G-F	Tast birthday) Yrs.	Months Months	Days	If Under 24 Hours	Min. 8.	Date of Birth (Month, Day,	Year)	9. Birth	lery nplace (State or Foreign untry)
			282-28-7977 Usual Residence of Decedent	76					S	ept.	21, 1	929	Georgia
	72 hours after death with the Maryland retural; or Iteme 23a or 28e-f show diest Examirat must be notified at		10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside City Limits
	89-f	cto	MD Montgom	ery Ch	evy Cl	hase							1 Yes 2 No
	with the Marylan a or 28e-f ehow Lbe notified at	Director	10e. Street and Number	-	2	10f. Zip	Code			1	0g. Citizen of	What Cou	untry?
	e 23s	ra	4515 Willard A	venue Ant.	2117	208	315				U.S.A		
	item Iren	Funeral	4515 Willard A	Amed Forces?	J.5. 113. V	Nas Decede f Yes, spec	ent of Hi rfy Cuba	spanic Origin n, Mexican, F	n? (Specif Puerto Ric	y Yes or No- can, etc.)		ace - Amer ack, White	rican Indian, n, etc.
936	ours after death w ai', or iteme 23a Examirac mant	þ	3√ Widowed 4 □ Divorced	1 ☐ Yes		1 ☐ Yes 2	X _{No}	Specify:			Spec		l-
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	0 0 5		10th 17. Father's Name (First, Middle, Last)		Cook						Resta		t
Maryland	ild be file lental Hyg ked othe ic event,	Be	_					18. Mother's	Name (F	First, Middle, N	Maiden Suma	me)	
Ž	hould d Mei mark matic	7	Matthew Brown 19a. Informant's Name/Relationship (7)	ima Print	10h Martia		(0)	Franc	cis :	Pace A	Asbur	У	
Ma	ith an 27 is 1rau			,						loute Number,			
ē,	Pages 1 and 2 should be ment of Health and Ments ant: if Item 27 is marked lury or other traumatic e	2000	Veronica Mance 20a. Method of Disposition	(daughter)	4515 Place of Dispos	Wil sition (Nam	lar	d, #5	19 _D	Chev	Char Oc. Location	SQ or T	MD 20815 own, State
Baltimore	Pages ment of ant: If It		Unit Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	OSMIGIBLY, CIGH	ratory or our	iei piace	" [1/	28/	06			
alti	in and		21. Signature of Funeral Service Licen.		22	. Name and	Addres	en Ce s of Facility			Avon,		
m	Depa Impo eny ii		Jenge ;	August	- y s	NOWDI	ENI	FUNER	AL H	OME, Rock	PA	MD	20050
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not ente	er the mode	of dying	g, such as car	rdiac or re	spiratory arre	VIIIE est,	7 MD	Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	Conge	Stive	e H	Pa	b	Ka	Cler	~ ·		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a donsed		Λ	h .	•	t ₁	(/000			300.093.
	A ST		Sequentially list conditions,	b. COVO	Mary	the	1er	7 0	dus	0220			4 Years
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of): 1			1					
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):								
8760,	icate be executed physicien and s the burial-transit	dical	(d									
89	tificat ng phy as th	ledi		V									
Вох	th cer lendir r use	an/N	250. Was decedent program	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Ectopic pre	00.2004				23d. Da	ate of deliv	ery
Э.	e dea he att	sicia	in the past 12 months?	4□Pregnant at time of o		Other (spe					M	onth	Day Year
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s,	ang en g	þ	Part II. Dther significant conditions co	ntributing to death but not res	sulting in the un	derlying cat	use giver	n in Part I.			1		the cause of death?
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Rec	has has be 2 s	Completed								24a. Was an autopsy		prior to co	opsy findings available ompletion of cause of
<u></u>	n: Tr ficate or, pa		05.144							perform 1 Yes 2		death?	2 No
₹	s cert	CD	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	lospital:	ER/Outpatient	3□ DOA	Othor			heck only one			
ō	er thi	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of		c. Injury : Work?	4 🗀 1401311		5 Resider			(y)
<u>0</u>	ath.	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	М		? es 2 □ No					
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory,	office		28f.	Location (Stree City or Town,	eet and Numi	ber or Rura	al Route Number,
Q	rs aft			N .						-	,		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certilicate ha completely filled in by the funeral director, page	Medicai	29a. Certifier to Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my kno	owledge, death	occurred at	the time	nion, death o	lace, and	due to the car	use(s) and m	anner as s	stated.
	thin 2 the implet	Med	29b. Signature and who of certifier	and manner stated.			License						
1	F 3 F 8		I TISAY	120M				at a	120		d. Date signe		Day, rear)
	V	-	30. Name and address of person who co	ompleted cause of death /line	n 23a) /Tuno P	Print)	1	001	122	5	1	101	D
			SAYED M. EL	SAYYAID 9		Wech!	n C	tate i	7-1	ocku	'lle, n	4D 8	20850
	Sta Registra		JAN 25 20	32 Registrar's Signa	ture	es)							

MARTIN, JACK F. 06-00759 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f, pen/F,0852,2/72/06 TT

T)			Unpend item#23a,2	,28a-f,penME,03 State of Man	3 52,2/22/0 6 /land/Dep	TT artment o	of Health a	nd Mental I	-lygien				
			1 - State Registrar	Otate of Mary			of Death	ind Mental i	Reg. N	200	6	035	E 0
			Decedent's Name (First, Middle, L	ast)				2. Date o	Death	1 No. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	U	3. Time of D	Death
	Physic /Medi		Jack Franc	is Martin				JANU	ARY 3	ð, 200	96 06	12:001	Р. М
	Exami		4a. Facility Name (If not institution, gi	ve street and number)			wn, or Location of			c. County o			
			2 WIMBLEDON LANE 5. Social Security Number 6.	Sex 7. Age (In	n yrs. last birthday)	If Under 1 Y	GS MILLS			BALTI			
0	Funeral Director			1 1 M 2 F 7. Age (#	50 Yrs.		Days Hours	Min. 8. Date of Month	. Dav. Year	955 V	9. Birthpi Coun Jashi	ace (State or try) ngton,	Foreign C
(/	2		Usual Residence of Decedent			1							
	ehov	5	10a. State 10b. County 10aryland Baltim		oc. City, Town or Lo Owings M						10	od. Inside City 1 X Yes :	
	ith the Marylar or 28e-f ehow a notified at	recto	10e, Street and Number			10f. Zip Co	vde.		10a C	itizen of Wi	hat Caus		
	h with	D	2 Wimbledon Lane			101. Zip 00	21117			U.S.A		ııy:	
	- deat	by Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent	t of Hispanic Orig	in? (Specify Yes of Puerto Rican, etc.	No-	14. Race			-
36	s afte	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 (ANo If Yes, Give		1 ☐ Yes 2		T donto riloan, atc.	'		, white, e Whit		
8	ture!	ed b	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual O	Occupation		16h k	Kind of Bus			
215	hin 72 Bn "nu Medii	piet	(Specify only highest gi Elementary/Secondary (0-12)		(Give	kind of work a DO NOT use n	done during most etired)					,	
2	ygien ygien her th	Completed	12	2	Wal	Lpaper	Special:			Wallp		Man	
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health, and Mental Hygiene. Inportant: if I tem 27 is marked other then "naturel", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examination in notified at 2008.	Be	17. Father's Name (First, Middle, Las Andrew Jackson					's Name (First, Michaeline M.			•		
Ž	should nd Me mark imatic	2	19a. Informant's Name/Relationship		19b. Mailir	na Address (St		or Rural Route Nu				Code)	
N.	alth a		Katherine M. Of		5606	N. 5th	Street	, Arlingt	on, Va	. 2220)5	0000)	
ore	of He of He if item		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 [Domoval from State	Ob. Place of Dispo cemetery, crei	natory or other	r place)	Date		ocation - C	•		
ţ	tment tant: jury c		4 ☐ Donation 5 ☐ Other (Special	(y)	National				05 Fa	lls	Churc	h, Va.	
Bal	permit. Depertr Importe any inju		21. grature Euneral Se vice Lice	Sell q			ddress of Facility Funeral I	451 Homes, v	0 Wil 'irgin	son E	31vd. 22203	,Arlin	gton
			23a. Part1. Enter the disease or con shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of	f dying, such as c	ardiac or respirator	y arrest,			Approximate Interval Betwo Onset and De	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Methadone In								Oriset and De	74(1)
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	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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687	ificate g physi as the t	edical		d									
Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-trans.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregn				23d. Date	of deliver	у	
	nt the dea by the att tached fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (specif)			_	Mont	h 1	Day Ye	ar
P.0	that the	Phy	Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	nderlying cause	e given in Part I	23e D	id tobacco	use contrit	oute to the	cause of dea	ath?
Division of Vital Records,	en sign	d by		•		.com, mg ozoo	o givor arracti.		□Yes 2			bly 4 DUn	
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/ita	ician: certifice rector, p	Be	25. Was case referred to medical examiner?				26. Place of	of Death Check on					
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Visi	Attendar death dector: A	ifica	3 ☐ Suicide 6 ★ Could not be determined	θ 20a Plana a/ Ini		7 21		28f Locatio	n (Street ar	nd Number	or Rural	Route Numbe	эг,
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	To the Hospital or Attsn within 24 hours after deat To the Funerel Director: completely filled in by the	edical Certification:	(Check only one)	niner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the restigation, in re	ne time, date and my opinion, death	place, and due to to occurred at the tin	he cause(s ne, date and) and manr d place, an	ner as sta d due to t	ted. the cause(s)	
	To th withir To th comp	M	29b. Signature and title of certifier	- 10		29c. Lic	cense number		29d. Da	ite signed (Month, D	ay, Year)	
_	(1)		(al Ille	· CAT			C.M.E.		JANU	ARY 3	1, 20	006	
X	0		30. Name and address of person who	completed cause of death	(Item 23a) (Type,		NN STREE	ET BALTIM					
	Sta	_	31. Date filed (Month, Day, Year)	2. Registrar's S					۱ وست	. 26 26 6 11 11 11	-1110	21201	
	Registr	ar	FEB 0 2-200	S Berin	& Augus								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item #28 per dr(verbal)/wichd/01-24-2006/dls Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 09:30 P.M 06 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bec Somerse tora lenus N CCSS QUA r 1 Year | If Under 24 Hrs. *1e* 8. Date of Birth (Month, Day, 9. Birthplace Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 M 2□F 230-18-0341 Usual Residence of Decedent 230-Director with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Exerciser must be notified at Somerse 1 XYes 2 ☐ No Directo INCESSONN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: Black 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Decedent's Education. 16b. Kind of Business/Industry (Specify only highest grade completed) mill Elementary/Secondary (0-12) Is marked other than College (1-4or 5+) borer 59peake 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumaine) Be thews MINNIC e5 (0 2 HENMEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 480 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei QNCE. Beckford Matthews Wife Princessanus And. 2/853 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1-24-06 Jelmar ` 4 ☐ Donation 5 Other (Specify) Crematory 22. Name and Address of Facility Bennie 21. Signature of Juneral Service Licensee Smith functal Home P.O. BOX331 Posomoko r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death the disease heart failur Immediate Cause (Final **Physician** disease or condition resulting in death) Carchimagalin /Medical Due to (or as a consequence of) Examiner i. Roll Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dualto for as a consequence of: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 🖺 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 1 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 → No 1 Inpatient 2 EB/Outpatient -3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-treet Salisbury, md. 21801 r. Stephen 605 Milford HEARNE 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 4 2006 Registrar

Registrar

			1 - For State Registrar	State of M	arylan	-	artmen tificat				F	Reg. No.	006	0356	5
	Physici	an	Decedent's Name (First, Middle, Las	")							2. Date of Dea Month	Day	Year	3. Time of	Death
	/Medic		Charles G								Januar	-	2006	7:25	РМ
	Examir	ıer	4a. Facility Name (If not institution, give						Location o	of Death			County of Death		
1	<u> </u>		Shady Grove Adven 5. Social Security Number 6. Se			In an injustralia.		ockvi	If Under 2	24 Hrs	9 Date of Bird		ontgome		. 5
e e	Funeral Director			X	65	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 6,		WI.	place (State or intry)	Foreign
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	ty Limits
	Mary 	to	MD Montgom	0 r 37			Cair	thora	burg					1 🗌 Yes	2 No
	within 72 hours after deeth with the Maryland one. then "natural", or items 23a or 28a-f ehow the Madical Examical must be natilised at	Funeral Director	10e. Street and Number	cry			10f. Zip		Durg			10g. Citiz	en of What Cou	intry?	
	th wit	aiD	22125 Creekview D	rive				208	382			Un	ited St	ates'	
	999 844	ner	11. Marital Status	12. Was Decedent Armed Forces		S. 13. V	Was Deced	dent of His	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	. 1	4. Race - Amer Black, White		
9	after or ft	F	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give			1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,		į		hite	
	ural',	d by	3 Widowed 4 Divorced	Year or Dates:											
7	nati	lete	15. Decedent's Ed (Specify only highest grad	ication le completed)		16a. Deced	dent's Usua kind of wo	al Occupa nk done d	ition J <i>uring m</i> os <i>t</i> I	of working	ng		d of Business/li	•	
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N D	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	J1		Luuca	CLOII			r's Name	(First, Middle,	Maiden :		OI.	
Maryland		To Be	Gerald Mertens								Kemen		- ,		
ar Z	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked eny injury or other traumatic evone.	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	r or Rural	l Route Numbe	er, City or	Town, State, Zi	p Code)	
ž	alth a		Julia Mertens / W	ife		22125	Cree	ekvie	w Dr	ive,	Gaithe	rsbu	rg, MD	20882	
altimore,	it He is		20a. Method of Disposition		l c	lace of Dispo-	natory or o	ne of ther place	9)		ate	20c. Loc	ation - City or T	own, State	
Ĕ	Page III		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		' Met	ropoli Cremat	.tan	,		Janua 200	ery 23	Ale:	xandria	. Virci	inia
a	partn ports y inju		21. Signature of Euneral Service Inicery	31	1	22	. Name an		s of Facility	y DeV	ol Fun	era1	Home,	10 East	:
m	88188		1 RACY A	ture	J	D	eer I	Park	Drive	e, Ga	aithers	burg	, MD 20	877	
	death certificate be executed Medical war / Medical war / Medical death of the set in the principle of the set in the principle of the set in the principle of the set in the se	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence a	Qrr/ uence of):	hyt							Interval Betwonset and E	veen)eath
/60	ite be nysicie he bui	cai		d											_
9	ng ph as th	Medi	IE EELMALE.												
O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Līve birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic pr Other (sp					2	3d. Date of deliving Month	-	/ear
<u>a.</u>	The law requires that the de ite has been signed by the bage 2 should be detached		Part II. Other significant conditions co	ntributing to death t	out not resi	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	obacco us	se contribute to	the cause of de	eath?
Records,	quires n sigr	d by	pneumon	1a, 5	eps-	is. h	UPO	xer	nia		1 🗆 Y	es 2 [No 3□Pro	bably 4	Jnknown
Ö	w rec	lete	/	,	/	,	/ /	•		, —	24a. Was	an	24b. Were aut	opsy findings a	available
E E	rsician: The law s certificate has b lirector, page 2 s	Completed									autop	rmed/	prior to co	ompletion of ca	ause of
ta	an: T	0	25. Was case referred to medical						26 Place	of Death	(Check only o	2 2000	1 🗆 Yes	2□ No	
5	ysici s cer direct	To B	examiner?	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 DC	Othe	r				Other (Spec	fv)	
0	g Phys er this eral dir		27. Manner of eath	28a. Date of Inju	ury	28b. Time of		8c. Injury Work			8d. Describe h			-37	
0	ath. r: After e funer	atio	Natural 5 Pending 2 Accident investigation	(INOTHER, DE	iy rear)	Injury	М		'es 2 □ N	No					
Division of Vital	To the Hospital or Attending Physician: within 42 hours after death to the Funeral Director. After this certifical completely filled in by the funeral director, it	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	jury - At ho tc. <i>(Specif</i>)	ome, farm, stre	eet, factory	/, office		2	8f. Location (S City or Tow		Number or Rui	al Route Numi	ber,
	To the Hospi within 24 hou To the Funer completely fill	edicai	29a. Certifier (Check only 2 Medical Examone)	rsician: To the best inar: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	and due to the ded at the time, o	date and	and manner as place, and due	stated. to the cause(s))
	Vithi Vithi To th	¥	29b. Signature and title of certifier	0			290	. License	number	^		29d. Date	signed (Month	Day, Year)	~
	10		> xulling	3				D4	25	18		101	nuary	12,2	206
			30. Name and address of person who co	ompleted cause of	death (Item	1 23a) (Турв.	Print)	Pive	9#40	01, i	Poese	vie	w, ow	805	52
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4	32. Ré gist			carte	P							

		1	For State Registrar	State of	Marylan		artmen rtificate			and M		eg. No.	06	0356	
I	Physici /Medic	an	1. Decedent's Name (First, Middle, Mary Frances Mu	-							2. Date of Dea Month Januar	ry 21	·	06 12:47	214
	Examin	er	4a. Facility Name (If not institution, Holy Cross Hosp	ital				ver	Sprin	ng _	O. Data of Birth			ntgomery	Faraina
	Funeral Director		5. Social Security Number 578-30-6362 Usual Residence of Decedent	3. Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs.	8 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day March 2	4, 19	27	Birthplace (State or Country) Washingto	
	e Maryland a-f show		10a. State 10b. County	gomery		y, Town or Lo Theaton								10d. Inside Cit	
	vith th	Dire	10e. Street and Number				10f. Zip	Code 20902	,		1	_	in of Wha ISA	t Country?	
336	d within 72 hours after death with the Maryland jiene. Ir than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	1213 Arcola Ave 11. Marital Status 1 Never Married 2 Marrie 3X Widowed 4 Divorced	12. Was Deced Armed Ford	es? ≛No		Was Deced	lent of Hi city Cuba	spanic Ori	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14	Race - A Black, V	American Indian, Vhite, etc. White	
21215-0036	within 72 hou ene. than "natura	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		lor 5+)		dent's Usua kind of wo DO NOT us	rk doné d se retired	during mos)	t of work	ing			ess/Industry Governmen	ıt
land 2	Hygi othar	To Be Co	17. Father's Name (First, Middle, L Raymond Charles	ast)		, 00		apile	18. Mothe		e (First, Middle, th Mae I	Maiden S	итате)		
ore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evonce.	85 8	19a. Informant's Name/Relationshi Mary E. Crider/ 20a. Method of Disposition 1 [38Burial 2] Cremation	Daughter		1213 Place of Dispo	Arcol sition (Nar	a Av	renue	, Wh	eaton, I Date ary 25,	Mary1	and		
Baltimore,	permit. Pag Department Important: any injury		`4 □Donation 5 □Other (Sp. 21. Signatus of Funeral Service L		Gate	e of Hea Fr	Name ag	d Addres	sof Facili	Yns	Funeral	Home	Inc	ring, Mar ng, MD 20	
}	Physician /Medical Examiner		23a. Part 1. Enter the disease, or canock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea aPancr	eas Ca	ncer	er the mod	le of dyin	g, such as	cardiac	or respiratory ari	rest,		Approximate Interval Betwoest and E Months	ween Death
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (c	ras a consec ras a consec										
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s, P	quires that n signed by	by	Part II. Other significant condition Sepsis	s contributing to dea	ith but not res	sulting in the u	inderlying o	ause giv	en in Part I			bacco us		ite to the cause of d □ Probably 4 🏝	
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f Vital	ysician: is certific director,	To Be C	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{XN} \)	Hospital:	patient 2	ER/Outpatie	nt 3 DC	Oth Oth	00		h <i>(Check only o</i> ome 5 ☐ Resid		□Other ((Specify)	
Division of	anding eath. or: After	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	ation of be 28e. Place of	, Day Year)	28b. Time of Injury	М		yat k? Yes 2⊡	No	28d. Describe h 28f. Location (S City or Tow	Street and		or Rural Route Num	ber,
Ö	To the Hospital or Att within 24 hours after d To the Funaral Diract completely filled in by t		29a. Certifier 1 XCertifying	Physician: To the to	pest of my kn	owledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) a	nd manni	er as stated. I due to the cause(s	:)
		Medical	29b. Signature and title of certifier	and manne	er stated.				e number			29d. Date	signed (A	Month, Day, Year) 22, 2006	
•	13		30. Name and address of person v Suresh K. Gupta	no completed cause	of death (Ite	m 23a) (Type, eorgia	Print) Avenu	ıe,	#220,	Si1	ver Spr	ing,	MD 2	0902	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 24	2006	gistrar's Sign	ature	ents.								

			1 - For Stata Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of I <i>rtificate of</i>		ental Hygier	CHILL TO	03563
10	Divisio		1. Decedent's Name (First, Middle, Las	")				2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		Diana Kay Middlek			* O' T	k	round.	25 2001 4c. County of Dear	0 4:4 HW
1	Examir	ner	4a. Facility Name (If not institution, give Washington County			Hagers	or Location of Death		Washing	
of the second	Funeral	~ ¹⁶⁰	5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign
	Director		168-34-1246	_M 2 ∑ F	61 Yrs.	Months Days	Hours Min.	March 3,1	944 Wes	t Virginia
	and w		Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	Maryland Washing	on	Hagerstow	n				1 ⊠Yes 2 □ No
	or 28a	lrec	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	ountry?
	23a o	alD	1036 Woodland Way			217			USA	
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic avent, the Medical Evantinal must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	0	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (Spectan, Mexican, Puerto P Specify:	ofy Yes or No- lican, etc.)	14. Race - Ame Black, Whit	e, etc.
215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				406		
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212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12)	College (1-4or 5	House	ewife	·	F	Home	
pu	be filled tal Hygi d other avent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		•	
Maryland	should be nd Mental marked o	၉	Robert	Vough				Arlene S		
Mar	d 2 sho in and 7 is mu traum		19a. Informant's Name/Relationship (7) Hugh E. Middlekau				t and Number or Rural	rstown, MD		Zip Code)
	Heal tem 2 other		20a. Method of Disposition	11,01. 1103	20b. Place of Dispo	isition (Name of	Da		Location - City or	Town, State
altimore,	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation \$ ☐ Other (Specify		1	natory or other pla g Cremat	tory 01-26-	2006 Smi	ithsburg	Crematory
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		21. Signature of Fuheral Service ticen		22	2. Name and Addre	ess of Facility Osbo	rne Funer		
			23a. Part I. Enter the risease, or composhock, or heart rilure. List only	lications that caused					Tumopor .	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lin		avce				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):					
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	uted d ansit	Examin	Sequentially list conditions, it any, loading Sommediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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68760,	ficate be executed physicien and is the burial-transit	edical		d						
	÷ 0.44		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	livery
Вох	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant at	2 Fetal death 3	Ectopic pregnance Other (specify) _	су		Month	Day Year
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	law requires that the es been signed by th 2 should be detache		Part II. Other significant conditions of	_	ut not resulting in the u	- //	,	N. F.		the cause of death?
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ita	ian: T	BeC	25. Was case referred to medical				26. Place of Death		NO TE TOS	2 140
) t	hysic his ce	မ	examiner? 1 Tes 2 No	Hospital: 1 Anpatie		IL SLIDOA		e 5 Residence		icity)
no	ling P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	Wo	ury at 2 ork?]Yes 2 □No	8d. Describe how in	njury occurred	
Division	death death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	-	ıry - At home, farm, sti			8f. Location (Street	and Number or R	ural Route Number,
Š	after after I Dire	Sert	4 Homicide	building, etc				City or Town, St	ate)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	/sician: To the best of iner: On the basis of and manner sta	examination and/or in	h occurred at the t vestigation, in my	time, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner a and place, and du	s stated. a to the cause(s)
	fo the within fo the comple	Med	29b. Signature and title of certifier	2		29c. Licen	se number	29d. l	Date signed (Moni	th, Day, Year)
	->=0		1	200	2)	Do	255799	1 1	1266	6
ب د د	1	6	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	1	1. ~	1101	6 FRSTOWN, MI
9	1-10	ii a	21 Date filed (Month Day Year)	901 HAM	r's Signature	11110 1	MEDICAL	CAMPUS.	DR. MMG	FRSTOWN, M.
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ORIGINAL

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			For Stata Registrar	State of Maryland	•	it of Health and I e of Death	Mental Hygier اروم	ZUUb	03564
P	hysici	an	1. Decedent's Name (First, Middle, Last,	DULIAGEI			2. Date of Death	Day Yeer 19 200	3. Time of Death 6 1220 M
	/Medic xamin		4a. Facility Name (If not institution, give	. /	4b. City	Town, or Location of Death	Danuary	4c. County of Dea	th
	neral		5. Social Security Number 6. Second Security Number 16. Second Security Number 16. Second Sec	S O 1 Ta 7. Age (In yrs. last	birthday) If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth		thplace (State or Foreign
D	ector		Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Location		105-0-1-19	144	10d. Inside City Limits,
ne Maryla	sa-r sho	ector	MO CAROL	INE FED	EZALS	BURG			1 Tyes 2 TNo
ath with ti	238 of 2	Funeral Director	10e. Street and Number 4032 PRESTO	N ROAD	2	1632	10g.	Citizen of What Co	ountry?
after des	or Items		11. Marital Status 1 ☐ Never Married 2 ☑ Marned	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
2 hours	ical Eza	ted by	3 Widowed 4 Divorced	Year or Dates:	6a. Decedent's Usu		rking 16b	. Kind of Business	/Industry
II Z IZ I J J J J J J J J J J J J J J J	Lis Mad	Completed	(Specify only highest grad	College (1-4or 5+)	FAR	NEZ MEZ	A	GRICU	LTURE
2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.	orant: if item 27 is marked other their in retural; or items 28 of 2884 show injury or other traumatic event, it a Madical Examinar mast be notified at 8.	To Be C	17. Father's Name (First, Middle, Last) WILLIAM F N	AGEL		18. Mother's Nar	ne (First, Middle, Maid E E VE	ten Sumame) ENABL	E3
id 2 shoulth and M	traumat		19a. Informant's Name/Relationship (T)	Per Print)	19b. Mailing Address	(Street and Number	ural Route Number, Cit	ty or Town, State,	Zip Code) 21 632
Pages 1 and 2	Important: If Item 27 any injury or other tr <u>2008</u> .	3	20a. Method of Disposition 1 W Burial 2 Cremation 3 F	come	e of Disposition (Na etery, crematory or	me of other place)	Date 20c	Location - City or	Town, State
permit. Pages Department of	Important any injury once.		4 Donation 5 Other (Specify) 21. Signitive of Funeral Service Licens	···	22. Name a	MANUS STERNING	JERAL HO	ME	21632
ا مه	5 a ol		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death. [31150 Do not enter the mo	de of dying, such as cardiad	or respiratory arrest,	EVERA	Approximate Interval Between
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The law requires that the death certificate be ex	been signed by the attending physicien and should be detached for use as the burial-transit	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy	ath 3 Ectopic p			23d. Date of de Month	olivery Day Year
at the de	d by the a	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown					
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Physical Phy	Affer this uneral di	lon: To	27. Manner of Death 1 Natural 5 Pending	Inpatient 2 LER		28c. Injury at Work?	dome 5 Residence 28d. Describe how in		ecify)
or Attendition death	n by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factor	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, S.		iural Route Number,
To the Hospitel or Attending Physicien:	To the Funeral Director: Aller this certificate has completely filled in by the funeral director, page 2	edical Ce		sician: To the best of my knowle					
To the within 2	To the Complete	Med	29b. Signature and title of certifier	and manner stated.		c. License number		Date signed (Mon	` '
			30. Name and address of person who co	ompower cause of death (Item 23) 3a) (Type, Print)		52	119/0	6
4.0	Sta	at a	Harder Sar	281mD	Ecrote	on, MD -	21601		
F	Registr		FEB _ 2 2006	2. Registrar's Signature	portes				

			1 - For State Registrar		State of	of Marylar				lealth a	and M		giene	11115		35	65
			1. Decedent's Name (First, Mic	idie, Last)			**					2. Date of De	ath			3. Time o	f Death
	Physicia		Nancy L.	N	lorris							January	21	2006	ar	8:50	Ам
	/Medic Examin		4a. Facility Name (If not institu	ion, give s	street and nu	mber)		4b. City	, Town, or	Location of	of Death		4c.	County of D	eath		
			Holy Cross Ho	spita	1			Sil	ver	Sprin	O.			Montg	Omei	~37	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Unde	n 1 Year Days	Sprin Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Nov . 1	h v Yearl	9.1	Birthpla	ce (State	o <i>r Foreig</i> n
	Director		215-46-2512	1	M 2⊠F	61	Yrs.	Month	Days	Tiodis		Nov. 1	,194	4 Of	iio	,, 	
	pu >		Usual Residence of Decedent 10a. State 10b. Cour	·hu		10c C	ity. Town or Lo	acation							100	d. Inside C	Site Limite
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	with t	ā	10e. Street and Number 11819 Dewey	Dond				101. 21	p Code 2	0906			-	izen of What Lted S		-	
	eath ns 23	Funeral Ofrector	11. Marital Status		12 Was Dec	edent Ever in U	IS 13	Was Dece			nin? (So	acify Vas or No		14. Race - A			
	ter d	'n	1 Never Married 2X M		Armed F	orces?	,	If Yes, spe	ecify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, W			
2	urs al	by	3 ☐ Widowed 4 ☐ Divord		If Yes, G Year or D	ive		1 Yes	2 💢 No	Specify:				Specify:	Whi	te	
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7	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ant, the Medical Evantiner must be notified at	Con	12			·	Admi	nistr	ativ	e Ass	ista	nt	Nuı	sing :	Home		
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yland	Ment Ment arkec	2	Kenneth Klei	nsorg	ze 					Mar ———	ion	Dunphy					
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It we also Evantret must be notified an once.		19a. Informant's Name/Relatio			1)		_				Al Route Number				-	
≥,	and salth n 27		Ernest C. Non	rıs	(Husba							ver Spr	-				
9	H iter	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic	n 3 □R	emoval from		Place of Dispo cemetery, crea				Jan.	26,		cation - City			
Ē	Pag ment ant:		`4 □Donation 5 □ Other			Pa	rlawn l	Mem.	Park	į		06	Roo	ckvill.	e, N	1d.	
baltimor	Depart Import any inj		21. Signature of Funeral Servi	ce Licanse	" ()	1/1	2:	2. Name a	nd Addres	ss of Facilit	y De	Vol Fun	eral	Home			
_	205 20		Cuttes	C.	New York	4)						r. Gait		sburg,			
			23a. Part1. Enter the disease, shock, or heart failure. L	or compli ist only on	cations that le cause on	each line.	th. Do not en	ter the mo	de of dyin	g, such as	cardiac o	or respiratory ar	rest,		1	Approxima nterval Be Onset and	te tween
	Physician		Immediate Cause (Final disease or condition	2	Муо	cardia1	Infar	ction	ı							Day	
	/Medical Examiner		resulting in death)		Due to	(or as a consec	quence of):										
	Examine		Sequentially list conditions, if any, leading to immediate	ь)	,											
	sit	Examiner	if any, leading to immediate cause. Enter Underlying	₹	Due to	(or as a consec	quence or):										
	eecut and I-tran	хап	that initiated events resulting in death) Last	0		(or as a consec	nuence of):								-		
700,	ate be executed hysician and the burial-transit			-	50010	(01 43 4 0011301	4001100 01).										
0	certificate be executed iding physician and ise as the burial-transit	edical		d	1										-		
O X O	ding se as	/Me	IF FEMALE:	2	3c. If ves. or	itcome of pregn	ancv							23d. Date of	dolinos		
	death in atten	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 ☐ Feta	aldeath 3	Ectopic p						Month			Year
o	the d	yslo	1 ☐ Yes 2 🛣No 9 ☐ Unknown		9□ Unkr		30411	3 0 1101 (3	pooy/								
Σ.	law requires that the death certifics as been signed by the attending pt 2 should be delached for use as t		Part II. Other significant cond	itions con	tributing to	leath but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	ise contribute	to the	cause of	death?
S	uires sign d be	d by										101	/es 21	□ No 3 □	Probab	oly 4X	Unknown
coras	w req beer shou	ompleted								_		24a. Was	an	24b. Were	autons	v findings	available
Ď L	9 4 9	dm										autop perfo:	rmed?	prior death	to comp i?	of contents	
2	ician: Th certificate rector, pag	e Co	OF Man area referred to mad	and .									2 X No	1 U Y	9s 2	□ No	
=	Physician: r this certific ral director,	o Be	25. Was case referred to med examiner?	-	lospital:	Innationt (197] ER/Outpatier		Oth	25		(Check only o		C COAh an (C	:6.1		
5	Phys	\vdash	1 ☐ Yes 2 📉 No 27. Manner of Death			Inpatient 2X of Injury oth, Day Year)	28b. Time o		28c. Injun Worl			me 5 🗌 Resid 28d. Describe h			респу)		
SION	ding F th. After funera	tlor	1 XNatural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Mor	nth, Day Year)	Injury	м		<br Yes 2 []!	No						
2	or Attending ifter death. Director: Aftel in by the fune	ertifications	3 ☐ Suicide 6 ☐ Cou	ld not be	28e. Plac	e of Injury . At h	nome, farm, st	reet, facto	ry, office		-	28f. Location (S			Rural F	Route Nun	nber,
É	after Dire	erti	4 Homicide		build	ling, etc. (Speci	ify)					City or Tow	m, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	alc	29a. Certifier 1 ☐ Certif	ying Phys	sician: To th	e best of my kn	owledge, deat	h occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner	as stat	ed.	
	n 24 n 24 ne Fu	edical	(Check only 2 Medic one)	el Exemir	ner: On the t and mar	pasis of examination	ation and/or in	vestigation	n, in my o	oinion, dea	th occurr	ed at the time,	date and	place, and o	due to th	ne cause(:	s)
	To the within 2 To the complet	M	29b. Signature and title of cent	tjer		21		29	c. License			1		e signed (Mo			
) (All TI	it	>	Physici	۲ ک		טטע	55694			Janu	ary 2	3, 2	2006	
	10		30. Name and address of pers														
			Dr. Alok Math			000 Oln		tonsv	ille	Rd.	01ne	y , Md.	208	332			
	Sta		31. Date filed (Month, Day, Ye	4 20	00 183	Registrar's Sign	ature	arts.									
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State The properties State The properties State The properties	lace (State or Foreign try) yland Od. Inside City Limits 1
George W. Neal 4b. City, Town, or Location of Death Suburban Hospital Bethesda Bet	ry lace (State or Foreign ty) yland Od. Inside City Limits 1 2 Yes 2 No try? es an Indian, etc. lored dustry nment Code) 20904 wn, State aryland
4. Facility Name (if not institution, give street and number) Suburban Hospital Social Security Number Social Security Numb	lace (State or Foreign try) yland Od. Inside City Limits 1
S. Social Security Number S. Social Security Number S. Sax F. Age (in yrs. last birinday) H. Under 1 Year H.	lace (State or Foreign try) yland Od. Inside City Limits 1
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10a. State 10b. County 10c. City, Town or Location 10d. City Town or Location 10d. Zip Code 10d. Z	1 Ayes 2 No try? es an Indian, etc. lored dustry nment Code) 20904 wn, State aryland
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Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Jue to (or as a consequence of): Due to (or as a consequence or): Due to (or as a consequence or):	20012
Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Jue to (or as a consequence of): Due to (or as a consequence or): Due to (or as a consequence or):	Approximate Interval Between
Examiner Sequentially that conditions is a final, leading to immediate cause. Eather Indeptying cause. Eather Indeptying	Onset and Death
if any, leading to immediate Due to (or as a consequence or):	
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IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliv	ry
FFEMALE: 23d. Date of delivery 23d. Date of deli	Day Year
O et p d e e e e e e e e e e e e e e e e e e	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to to the part II. 1 Yes 2 No 3 Protection of the part II. 24e. Was an 24b. Were auto	ably 4 Unknown
e e e e e e e e e e e e e e e e e e e	
Prostate Cancol 24a. Was an autopsy for performed? Second Prostate Pro	psy findings available inpletion of cause of
T	2□ No
examiner? 2 Indicate the special control of t	<i>(</i>)
The state of light st	
C C C C C C C C C C C C C C C C C C C	
23c. If yes, outcome of pregnancy	l Route Number,
Suitility, etc. (Specify) 29a. Certifier (Check only of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as some and manner as some and manner as some and manner and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as some and manner and manner as some and manner as some and manner and man	ated
29a. Certifier 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a contribution of the cause (s) and	atou.
The state of the s	the cause(s)
	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Giscalle Marry M.D.	othe cause(s) Day, Year)
4416 East West Highway Suite 410 Bethesda, MD ZOE	othe cause(s) Day, Year)
State Registrar JAN 2 0 2006 State Registrar	othe cause(s) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear 23, 2006 5:00 p Jan. Mary Jane O'Reilly Overall 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 119 East Melrose Court Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1□M 2X)F 83 July 4, Missouri 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian, Black, White, etc.

20815

Chevy Chase, MD

Chevy Chase

5. Social Security Number **Funeral** 493.24.0243 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importsnt: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinal minal be published at once. 10a. State Directo MD 10e. Street and Number 119 East Melrose Court 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Be Completed by Physician /Medical Examiner

Montgomery

Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Ame Black, Whit	
1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 【XNo If Yes, Give	1 ☐ Yes 2 💢 No			Specify:	White
3 ☐ Widowed 4 M Divorced	Year or Dates:	10a Danadania Haval Osav		16h	Kind of Business	/Industry
15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	g 166.	Kind of Business	industry
Elementary/Secondary (0-12)	College (1-4or 5+) 2	Homemaker	۵,		Own_H	ome
17. Father's Name (First, Middle, Last,			18. Mother's Name	(First, Middle, Maid	en Sumame)	
Joseph O'Re:	illy		Frai	nces Flan	agan	
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural	Route Number, City	y or Town, State,	Zip Code)
Clemence Overall,		520 State St	reet Dove	r, Delawa	re 1990	1
20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Pemoval from State	ce of Disposition (Name of netery, crematory or other pla			Location - City or	Town, State
`4 □Donation 5 □ Other (Specif	(y)	Calvary Cemet				est Virgini
21. Signature of Fun ry Servi Licer	nsee		ess of Facility Jose Onsin Avent	•		, Inc.
1/100/1/	- I'					Approximate
23a. Part 1. Enter the disease, or com shock, or leart failure. List only Immediate Cause (Final	one cause on each line.	tructive Pulm				Interval Between Onset and Death 15 years
disease or condition resulting in death)	Due to (or as a conseque		Jiary Disc.			
Sequentially list conditions,	b	ance of				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ance or):				
that initiated events resulting in death) Last	C. Due to (or as a conseque	ence of):				
	d					
IF FEMALE:	20-16					r
23b. Was decedent pregnant in the past 12 wonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic pregnance	Sy		23d. Date of de Month	Day Year
Part II. Other significant conditions	contributing to death but not result	ting in the underlying cause o	ven in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
Coronary Artery				1 🔀 Yes	2 No 3 P	robably 4 Unknow
				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of s
25. Was case referred to medical			26. Place of Death			
examiner? 1 ☐ Yes 2 🛣 No			her: 4 🗆 Nursing Hon	ne 5🎇 Residence		ecify)
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury Wi	iryat 2 ork?]Yes 2 □No	8d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	2	8f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
29a. Certifier 1 X Certifying P (Check only one)	hysician: To the best of my know miner: On the basis of examination	vledge, death occurred at the on and/or investigation, in my	ime, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
/	aria manior statos.					
29b. Signature and title of certifier	1 1	29c. Licer	ise number	29d.	Date signed (Mor	th, Day, Year)

Registrar

32. Registrar's Signature

5530 Wisconsin Avenue #925

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kevin Nealon, M.D.

Date filed (Month, Day, Year) JAN 2 6 2006

1. Decedent's Na

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

0815 M

	Certificate of Death	Reg	ig. Nd UUD			
me (First, Middle, Last)		2. Date of Death Month	Day	Year		
Robert Pavlovsky		January	130	2006		

Physician /Medical Examiner

Direct

12

Funeral Director

Item 27 is marked other then "natural", or Items 23s or 28s-4 show other traumatic event, the Medical Examinar must be notified at e filed within 7 Il Hygiene. 2 should be t and Mental h permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny injury or other traum once.

Pavlovsky, Georg

Physician /Medical Examiner

burial-tran the attending physicien certificate be use as the signed by the a funeral Hospitel or Attending P. 24 hours after death.
Funerel Director: After to filled in by

Box 68760

P.0.

Division of Vital Records.

Examiner Physician/Medical ģ Completed Certification: within 24 hours a

To the Funerel C

completely filled

George Robert Pavlovsky 4a. Facility Name (If not institution, give street and number) Memorial Hospital at 5. Social Security Number 1**X**M 2□F 220-26-7934 Usual Residence of Decedent 10a. State 10b. County

Easton 7. Age (In yrs. last birthday) Yrs

4b. City, Town, or Location of Death Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 18 1924

Talbot Birthplace (State or Foreign
Country) Connecticut

10c. City. Town or Location

10d. Inside City Limits 1 ☐ Yes 2 No

Maryland Caroline Goldsboro 10e. Street and Number 26059 Goldsboro Road

01

21636 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

14. Race - American Indian Black, White, etc.

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

U.S.A.

4c. County of Death

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 1/45-7/46 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

1 ☐ Yes 2X No

Dover Air Force Base

White

17. Father's Name (First, Middle, Last)

John Pavlovsky

20a. Method of Disposition

1 ☐ Never Married 2 X Married

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Magut Pavlovsky

19a. Informant's Name/Relationship (Type, Print) Mary W. Pavlovsky/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 3 2006

Inspector

26059 Goldsboro Road, Goldsboro, Maryland 21636 Date 20c. Location - City or Town, State

Dover, Delaware

1 X Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses

Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

neumonia Due to (or as a consequence of) Chronic

obstructive lung disease

Approximate Interval Between Onset and Death Years

Year

E equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

3 Ectopic pregnancy

23d. Date of delivery Month Day

IF FEMALE 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ray Kinson's discase

24a. Was an autopsy performed? res 2.24% 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔊 No

2 Accident

3 ☐ Suicide

29a. Certifier

27. Manner of Death 1 Natural 5 Pending Hospital: 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 4 Homicide

investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

LVand

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) JANUARY 30 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

akshm Vaidyangthan 219 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB

State Registrar

		For State Registrar	State o	f Marylar		artment rtificate							6	03569
Decedent's Name (First, Middle, Last)							2. Date of D Month			Day Year		3. Time of Death		
Physici /Medio	_	Lucille S. P	Januar			-			10:10 P M					
Examir		4a. Facility Name (If not institution,				4b. City, T					4	,		
		Sunrise Assist		7. Age (In yrs.	last histoday	If Under		Parl If Under		B. Date of Bir	rth.	9 Birtholago (State or Foreign		
Funeral Director		5. Sociat Security Number 219–18–8754	6. Sex 1 □ M 2 🔀 F	82	Yrs.	Months	Days	Hours	Min	. (Month, Da 2-14-1	av. Yea	ar)		
		Usual Residence of Decedent												10d Inside Challimite
nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation								
Be-1 s	cto	Maryland Anne A	rundel		Mil	lersv					10a i	Citizon of M	Vhat Cou	
vith th	Dire	10e. Street and Number 212 Serenade Co	1.20c+			10f. Zip	1108						vilat cou	muy:
s 23s	rai			edent Ever in U	J.S. 13.				igin? (Spec	ify Yes or No		14. Race		
tter de	Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Marri	Armed F ed 1 ☐ Yes	orces? 2 X No						ify Yes or No ican, etc.)			1	
hours after death with the Maryland tural, or Items 23a or 28e-f show al Examinal must be redified at	é	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:				1 ☐ Yes 2X No Specify:				Specify: WILLE				
d within 72 hours after death with the Marylar giene. giene "ratural", or Items 23a or 28e-f show the Medical Examinar must be inditied at	Completed	15. Decedent (Specify only highes	's Education it grade completed,)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>Juring m</i> os	st of working	g	16b	ac. Country of Death Anne Arundel 4c. Country of Death Anne Arundel 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1		
within 72 ho jiene. r then "natu	ig m	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		keepe		,				tate!	of M	faryland
filed v Hygie other t	ပိ	17. Father's Name (First, Middle,	Last)		BOOK	rveebe	1	18. Mothe	er's Name	(First, Middle				MI y I CIRC
od ita	o Be	Terry	Sakellos	5					A	ngelin	ıa	Ep	sinl	antis
should be nd Menta marked	10	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ing Address	(Street a	and Numb	er or Rural	Route Numb				p Code)
		George Z. Petr	os/ Son		212	Seren	ade	Ct.,	Mill	ersvil	le,	MD 2	1108	3
rmit. Pages 1 ar partment of Hea portent: If item: y injury or other		20a. Method of Disposition 1XXBurial 2 ☐ Cremation			Place of Disponentery, cre	osition (Name	ne of ther place	a)	Da	ite	20c	Location -	City or T	own, State
permit. Pages Department of Importent: If it any injury or o		4 Donation 5 Other (S		St	t. Deme	etrios	Cem		1-24-	06	P	nnapo	lis,	Maryland
permit. Pa Departmen Importent: any injury		21. Signature 4 Juneral Service	dicensee		2	2. Name an	d Addres	s of Facili	ity Geo:	rge P.	Ka	las F	uner	al Home
907 2 9		flower o' cla	us									ewate	er, M	
		23a. Part. Enter the disease, or complications that caused the death. But of the find the mode of dying, such as calculated in Spiritary and Death of Spiritary												
Physician											hours			
/Medical Examiner		resulting in dodainy	Due to	or as a conse	quence of):									
	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c												
ite be executed ysician and ne burial-transit		resulting in death) Last	Due to	o (or as a conse	quence of):									
	ical		d										-	
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy										23d Date of delivery		
ires that the death cersigned by the attending be detached for use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tive birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify)										
he de the a	ysic	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□ Unk		ueau 3	Other (3)2	- Ciny)					1		
that t	F P	Part II. Dther significant condition	onditions contributing to death but not resulting in the underlying cause given in Part 1.					23e. Did	3e. Did tobacco use contribute to the cause of death?					
quires n sign ald be	D	H/Zheir	ner s	de	men	tion				1 🗆] Yes	2 🗆 No	3 🗆 Pro	obably 4 Tunknown
he law requires t e has been signe age 2 should be	Completed									24a. We	ış an opsy	24b.	Were au	topsy findings available
sician: The la certificate ha lirector, page 2	mo.									per 1 ☐ Yes	forme	1?	death?	
	Be C	25. Was case referred to medica						26. Plac	ce of Death	(Check only	one)		,	Assiste
Physician: this certific ral director,	To	examiner? 1 Tes 2 Tho	-		☐ ER/Outpatio			4 L IV		ne 5□Re				city) LIVING
ding Phy h. After thi funeral		27. Manner of Death 1 V Natural 5 ☐ Pendi	28a. Dat (<i>M</i> o	e of Injury onth, Day Year)	28b. Time Injury		28c. Injur Wor	yat k? Yes 2.[28d. Describ	escribe how injury occurred			
Attending r death. sctor: After by the fune	cati	3 Suicide 6 Could	not be 200 Rio	ce of Injury - At	home farm s	M factor		185 2		28f. Location (Street and Number or Rural Route Number,				ıral Route Number,
I or Attending Phy after death. Director: After this d in by the funeral d	Certification:	4 Homicide determ	ninod 200. Fld	Iding, etc. (Spe	cify)	rioot, racion	,, onice							
To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	S E	29a. Certifier (Certify)	ng Physician: To t	he best of my k	nowledge, dea	ath occurred	at the tir	ne, date a	and place, a	and due to th	ne caus	se(s) and m	anner as	stated.
• Hos 24 h	edical	(Check only 2 Medical one)	Exeminer: On the and ma	basis of exami anner stated.	nation and/or	investigation	ı, in my c	pinion, de	eath occurr	ed at the time	e, date	and ptace,	and due	to the cause(s)
To th within To th compl	₩	29b. Signature and title of certifie	er .	2		29	c. Licens	e number	2	0	29d	. Date signe	ed (Mont	n. Day, Year)
		W V			M	()	1	150)/c	×5		0	()	- 2000
		30. Name and address of person	who completed ca	use of death (оп-23а) (Тур	e Print) L	00-		11	1 1	1:	1 love	1 ,20	1. Minall
		Jenni Terk	riedina	yor 8	001	vere	A a.	ns 7	Jul	7 10	41	NUTS	VIL	ce jour
- S Regis	tate	31. Date filed (Month, Day, Year	2066	Registrar's Sig	majure				0					
negis	uel	عرف معالقة		-										

State of Maryland / Department of Health and Mental Hygiene () () 03570 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AM 25 0210 M. Parsons 2000) Gro this)GN /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.

Oavs Hours Min. Archarage Wicerrico Nursing + Rehab Cent 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 X F 91 August 8,1914 Maryland Director 214-10-6399 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State od other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 105 Times Square Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manhatten Shirt Factory Seamstress 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Emma Timmons Jerome Samuel Moore ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6788 Walston Switch Rd. Salisbury, Maryland 21804 Robert Ruark/ Nephew 20b. Place of Disposition (Name of cometery crematory or other place)

Jerusalem UMC Date 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 1/28/06 Parsonsburg, Maryland any in ury Cemetery ocalure of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 Jarre 4. CFSP Kompoor 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE HEART Immediate Cause (Final LONGESTIVE 20 DAYJ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CARDIOMYO PATHY YEAR Examiner SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CHRONIC RENAL 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 2 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINTER HIRAZI, MD. 31575 32. Registrar's Signature 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	Later Sea		For State Registrar	State of Marylar		artment of F ertificate of		nd Men		ene g. No.	06	03571
	Physici	an	1. Decedent's Name (First, Middle, La	st)					Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Roger William Pot			4b. City, Town, o	or Location of	Death	anuary	21 4c. Cou	zooy inty of Death	23:50 P ^M
*	Examin	er	Pedinsula Regional		P	3	0456411	/			Hicomic	
蒙	Funeral Director		5. Social Security Number 6. S 158–05–9307		last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth 'Month, Day, ril 29		Co	hplace (State or Foreign untry) Jersey
.0036 hours after death with the Maryland	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
	e Mar	ctor	Maryland Wicomic	Sa.	lisbur	У						1X Yes 2 No
	with th	Directo	10e. Street and Number 1018 Adams Ave Ap	s+ 2D		10f. Zip Code 21804			10	g. Citizen USA	of What Co	untry?
	ns 234	Funeral	1010 Additis Ave Ap	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cub	lispanic Origin	in? (Specify	Yes or No-		Race - Ame	rican Indian,
	s filed within 72 hours after death with the Marylar I Hygiene. other then "natural", or Items 23s or 28s-f ehow vent, It.a Modical Exercitor for at the notified	by	t ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: US N		If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, I Specify:	Puerto Rica	ın, etc.)		Black, White ec <i>ity:</i> Wh	e, etc. Lite
215-0036	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup e kind of work done	during most o	of working	1	6b. Kind	of Business/I	Industry
212	within lene. then "	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		tenance S		sor	R	ubbei	set	
	e filed withing Hygiene. other ther	Be Co	17. Father's Name (First, Middle, Last				_		rst, Middle, M			
Maryland	2 should be and Mental I is marked o	To E	Charles Hurlbert 1	Potter			Flore	ence I	rene B	lizza	ard	
Mar	C (4 -= 0		19a. Informant's Name/Relationship (Friedel M. Potter)			ling Address (Street Adams Av						
	Health tem 27 other tr		20a. Method of Disposition	20b. i	Place of Disp	osition (Name of		Date	_		on - City or	
altimore,	Pages nent of int: if it		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			mited"Met emetery	Modist	: 1/25	/06 M	ount	Verno	on, Maryland
<u>a</u>	pernit. Pages Department of Important: If it any njury or o		ignature of Funeral Service Licer	, 011		22. Name and Addre	ss of Facility				, C2110	,
10 	g o = ≅ g		David 4. 46	mysom CFS	SP 5	Ol Snow H	ill Rd	. Sal	isbury		yland	
4			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	uanca of	1 In	Lock	2				lay
	Examiner		Constitution and the second	h Caran	A	I In	-1					5%
4	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):								
	xecute and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	consequence of):						-	
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9	rtificat ng phy s as th		IF FEMALE:					-		1	. 1	
J. Box	e death certifica the attending ph ned for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у			23d.	Date of deli Month	ivery Day Year
P.O.	that the	Phy									contribute to the cause of death?	
rds,	w requires that the de been signed by the should be detached	d by							1 ☐ Ye	s 2 2 N	2 No 3 Probably 4 Unknown	
Records,	= 1001	Completed					** ****		24a. Was ar autopsy perform 1 ☐ Yes 2	/	4b. Were au prior to death?	topsy findings available completion of cause of
Ita		BeC	25. Was case referred to medical examiner?				26. Ptace o	of Death (C	heck only one			20,110
5	Physician: r this certifica ral director, i	မ	1 ☐ Yes 2 ☑ No		ER/Outpatie	MIL SLIDOA			5 Reside			cify)
u O	ding h. h. After funer	tion	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk? ∣Yes 2.∐No		Describe ho	w injury od	currea	
Division of Vital	of or Attending Peler death. Director: After to in by the funera	Certification:	3 Suicide 6 Could not be determined	0 51(1-: 445	ome, farm, s fy)				Location (Str City or Town	reet and N . State)	umber or Ru	iral Route Number,
	To the Hospitel of within 24 hours of To the Funerel D completely filled in	Medical C	29a. Certifier Certifying Pl (Check only one)	nysician: To the best of my known in ar: On the basis of examination and manner stated.	owledge, dea ation and/or i	ath occurred at the ti nvestigation, in my o	me, date and opinion, death	place, and occurred a	due to the ca it the time, da	use(s) and ite and pla	d manner as ce, and due	stated. to the cause(s)
	To the within To the comp	ĕ	29b. Signature and title of centifier			29c. Licens	se number		29	d. Date si	gned (Monti	h, Day, Year)
)		3	1/100	my		1/05	54	79	2	2//	22/	96
	(bh)	14	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)	218	201		,	,	
- 100 m	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 2006	32. Registrar's Sign	ature		~ (0	<i>-</i> /				

218-16-6473

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Division

			Please T	ype or Print in B	lack Indelib	le Ink. Ensure A	II Copies A	re Legible.		
f	*		_ For	State of Maryland	d / Departme	nt of Health and	Mental Hygie	menn n	03572	
			1 - State Registrar Amended iter	#29d per dr/	wichantifica	te of Death 1-2	5-2006/dds	No.	UUUIL	
٠.	Physici	an :	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	_	Willian	o H. Tu	rnell,	3R	01 18	2004	0420 "	
	Examin	er	4a. Facility Name (If not institution, give s	Medica a	antu	7, Town, or Location of Death		4c. County of Death,		
NO.	Funeral Director		218-16-6913	M 2□F 7. Age (In yrs. Ia	Yrs. If Und Months	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, You	ear) Cou	place (State or Foreign http)	
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artifrent of Health and Mental Hyglene. ortant: if Item 27 is marked other then "natural", or Items 23e or 28e-f show injury or other traumatic event, tre Medical Everther regal be nutited at injury or other traumatic event.	tor	MO Wicom	ico 5	Alisbu	0.1			1 Yes 2 □ No	
	th the	Director	10e. Street and Number	Λ		ip Gode	10g	. Citizen of What Cou	ntry?	
	23a c	aiD	400 PARK 1	trenue		21826		U.SA		
	tems	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,		
36	rs after ', or ite	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 □ No If Yes, Give	1 ☐ Yes			Specify: Q/	V	
21215-0036	72 hours 'natural', dical Eva		15. Decedent's Edu	Year or Dates:	16a. Decedent's Us	ual Occupation	16	b. Kind of Business/In	dustry	
212	hin 72 on "nu Medil	piet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of w	ork done during most of wo	rking	S. T		
2	filed within Hygiene. Ither then and, Ire Me	Completed	6th	Conogo (1 401 51)	Diesel	Mechanic	R	eston hus	KING O	
nd	d oth	Be	17. Father's Name (First, Middle, Last)		11	18. Mother's Nar	ne (First, Middle, Ma.	iden Sumame)		
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Maryland	d 2 sho th and 7 is my traum		19. Informant's Name/Relationship (Ty	De, Printi)	19b. Mailing Addre	s (Street and Number or Ru	5.1.1.	ity or Town, State, Zip	Code)	
	Health tem 27 other tr		20a. Method of Disposition	20b. Pl	ace of Disposition (N	ame of	Date Date	Location - City or To	own, State	
OL	Pages nent of int: if it		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crematory or	other place)	22/11.	Contra	110	
Baltimore	permit. Pag Department Important: f any Injury o		21. Signature of Funeral Service License		7.1	and Address of Facility	910	W. Took	112.5+.	
m	Depa Impo any Ir		Irvscilla	Konneds	Bennie	- Smith French	1 Home SA	Hisbury +	10 21801	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest	. /	Approximate Interval Between	
1 %	Physician		Immediate Cause (Final disease or condition	Granas	artei	Deseo	- >	4	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	0	1			
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	uted 1 Insit	min	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		æ		-	000	
oʻ	be executed cian and ourial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):			-	200	
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c 687	ing ph	Med	IF FEMALE:							
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal	death 3 Ectopic			23d. Date of delivery Month Day Year		
	he de the a	Physician/Medica	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	ath 5 ☐ Other (s	pecify)		Monar	Day Tout	
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Division of Vital Records,	The law requires that the death certificate site has been signed by the attending physege 2 should be detached for use as the	d by					1 🗆 Yes	2 No 3 Prob	pably 4 Unknown	
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/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)			
5	physic this o	2	1 □ Yes 2 X No	ospital: 1 Inpatient 2				e 6 Other (Specific	y)	
UQ.	ding h	Hon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
<u>Isi</u>	or Attending Physician: after death. Director: After this certifici in by the funeral director. I	fica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor			28f. Location (Stree	Location (Street and Number or Rural Route Number,		
á	al or A s after il Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify,)	.,,	City or Town, S	State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowner: On the basis of examinati and manner stated.					tated. the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier	Side in States.	25	c. License number	29d	Date signed (Month,	Day, Year)	
	, , , , , ,		1 man	then		22516	9	43514	4 1-25-AI	
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	-120		100	100-00	
			William ROBINS	mpleted cause of death (Item M.O. 100 32. Resistrar's Signat	WIC AVE.	salisbum 1	mo 21804	/		
75,	Sta		31. Date filed (Month, Day, Year) JAN 2 5 2	32. Registrar's Signat	M A					
Mar.	Registr	वा	20 2	MEGENERAL J	C ESTAGE					

State of Maryland / Department of Health and Mental Hygiene Ub Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 22, 8:45p M Margaret Popp January 2006 Υ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Hillhaven Nursing Center, Inc. Adelphi If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 89 235-07-6142 Jan. 19, 1917 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location worle 10a, State 10b. County r 28a-f ehow 1 ☐ Yes 2 TXNo Directo Hyattsville Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r then "naturel", or items 23a or the Medical Examiner must be 2410 Griffen Street 20783 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itel many injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Micklos Louis Yuhasz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2410 Griffen Street, Hyattsville, MD 20783 Alex Popp/ Son Date 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 XBuriai 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) Francis J. Collins Funeral Home Inc 21. Signatur ole MD 20901 500 University Blvd, W, Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Year End Stage Renal Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 Years Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed 15 Years Diabetes Mellitus Type II resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes 25 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funerel Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) the 29d, Date signed (Month, Dey, Year) 29c. License number 29b. Signature and January 23, 2006 D31563 Deller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 20901 egistrar's Signature 31. Date filed (Month, Day, Year) State JAN 24 2006

DHMH 17 Rev 1/2001

Registrar

	1- State of Maryland /	Department of Health and I Certificate of Death	Mental Hygiene 0 0 6 0 3 5 7 L
Physician	1. Decedent's Name (First, Middle, Last) BERNARD, PENNY		2. Date of Death Month Day Yeer 19:26 M
/Medical Examiner		4b. City, Town, or Location of Death Bethesda	200 7
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 577-62-5430 1 1 4 2 F 64	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign JAN. 30, 1941 Poland
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic avent. Its Mariles Examines mustified at once. To Be Completed by Funeral Director	5. Social Security Number 577-62-5430 Usuel Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Montgomery 10e. Street and Number 6604 Millwood Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Joseph Penny 19a. Informant's Name/Relationship (Type, Print) Toba Penny - Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fungral Service Licensee 23a. Part I Enter the disease, or complications that caused the death. Disposition resulting in death) Due to (or as a consequence of Sequentially list conditions resulting in death) Sequentially list conditions	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Days Hours Min. Bethesda 10f. Zip Code 20817 13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: 1a. Decedent's Usual Occupation (Give kind of work done during most of workife. DO NOT use retired) Scientific Linguist 18. Mother's Name Helen 9b. Mailing Address (Street and Number or Rues) Address (Street and Number or Rues) Hebrew Cemetery O1 22 Name and Address of Familia Full 1800 New Hampshi on not enter the mode of dying, such as cardiac of:	8. Date of Birth JAN. 1941 9. Birthplace (State or Foreign Polarid) 10d. Inside City Limits 1 Hyes 2 □ No 10g. Citizen of What Country? United States of Americ pecify Yes or Noo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Department of State 16b. Kind of Business/Industry Department of State 16c. City or Town, State, Zip Code) ethesda, Maryland 20817 Date 20c. Location · City or Town, State 1724/06 Baltimore, Maryland neral Home, Inc. re Ave. Silver Spring, MD 2090 Approximate Interval Between Conset and Death
S, P.O. Box 68760, es that the death certificate be executed gned by the attending physician and be detached for use as the bunal-transit by Physician/Medical Examiner	cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence d.	e of):	23d. Date of delivery Month Day Year
		g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
I Recor The law requete has been page 2 shoul			24a. Was an autopsy findings available prior to completion of cause of death? 1 Ves 2 No 1 Yes 2 No
on of V ding Physic h. Atter this of tuneral dire	27. Manger of Death 1. Natural 5 Pending (Month, Day Year) 2. Accident investigation 2. Suite of 1. Control of the	Outpatient 3 DOA Other: 4 Nursing H Time of Injury M M 1 Yes 2 No	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
<u> </u>	4 Homicide determined 299. Pace of injuly stribble, building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowled	ge, death occurred at the time, date and place	28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated.
To the Hosp within 24 hou To the Fune completely fill	29b. Signature and title of certifier Annual Medical Examiner: On the basis of examination and manner staled.	29c. License number	29d. Date signed (Month, Day, Year) Lanuary, 22, 2006
State Registrar	30. Name and address of person who completed cause of death (Item 23a 8600 0.D GEORGETOWN RD). 31. Date filed (Month, Day, Year) JAN 2 4 2006	BETHESDA MD 2	20814

d.	1		-	State of Mary				Mental Hvo	_	
			1 - For State Registrar			rtificate d		, ,	leg. No.	6 03575
	Physici	an	1. Decedent's Name (First, Middle, Li Melvin Ha	. '	tta			2. Date of Dea Month	Day Y	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi			4b. City. Tow	n, or Location of De		7 18, 200	
	Examin	er	328 Dry Run Road	TO STOOL BIG TOWNSON		Swanto			Garrett	
	Funeral		Social Security Number 6.	Sex 7. Age (In 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	yrs. last birthday) Q Yrs.	If Under 1 You Months Da	ear If Under 24 H		1	Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent	A 0:	J 113.			000.13	,1930 1	Marÿland
	death with the Maryland ima 23a or 28a-f show rimust be notified at	2	10a. State 10b. County MD Ga:		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	28a-f	Funeral Director	10e. Street and Number	rrett	31	wanton			10g. Citizen of Wh	
	h with 23a or	al Di	328 Dry Run Re	oad			21561		US	
	er deat	uner	11. Marital Status	12. Was Decedent Ever Amed Forces?	r in U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Black,	- American Indian, White, etc.
5	within 72 hours after death with the Marylar ene. Han "natural", or Itema 23s or 28s-f show ha Madical Examinar must be notitied at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1X X es 2 □ No If Yes, Give Year or Dates: K (orean	1□Yes 2【X	No Specify:		Specify:	White
2-003p	72 hou nature lical E	ted	15. Decedent's E (Specify only highest gi	Education		dent's Usual Oc	cupation one during most of v tired)	working	16b. Kind of Busi	ness/Industry
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7 0	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Las	t)		Work		lame (First, Middle,		Construction
Jan	Aental Aental rked c	To Be	Harry D.	Pritts			Lei			Vright
a J	nit. Pages 1 and 2 should be filed within triment of Health and Mental Hygierie. ortant: If Item 27 is marked other than Injury or other traumatic event, Ins. Me. 8.		19a. Informant's Name/Relationship					Rural Route Number		
و م	s 1 and if Heelth Item 27 other tr		Sue Steyer/ No					ing Road	, Uakla 20c. Location - C	
	Pages nent of int: if it iry or o		1 ∑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		Ob. Place of Dispo cemetery, crei George			22/06		on, MD
Saitimor	permit. Page Department of Importent: if any Injury or once.		21. Signature of Funeral Service Lice	A	_		-	tewart F		· · · · · · · · · · · · · · · · · · ·
۵_	Ded Impo	b 55	> Seedy 15	Delin	32	2 S. 2	nd. St.	, Oaklan	d, MD	21550
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line.	death. Do not ent	er the mode of	dying, such as card	iac or respiratory arr	rest,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HY POTHERS Due to (or as a co		MPLICA	TING ATHI	EROSCIEROT	ic	
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	ensequence of):					
	be executed Ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	insequence of):					
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00	ing phy		IF FEMALE:	34						
Š D	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetel death 3	Ectopic pregna Other (specify			23d. Date Monti	
j	the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	901004(11 5	Other (specify				
n L	sicien: The law requires that the death certificate be executed certificate hes been signed by the attending physicien and rector, page 2 should be deteched for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause	given in Part I.			ute to the cause of death?
necords,	requir een si hould					· · · · · · · · · · · · · · · · · · ·		- 1 Y	es 2 □ No 3	Probably 4 Wunknown
ည ည	hes b	Completed						24a. Was a autops	sy pri	ere autopsy findings available or to completion of cause of ath?
N I G	an: Tr tificete tor, pa	0	25. Was case referred to medical		<u></u>		26 Place of F	1 XYes Death (Check only or	2 □ No 1 1 2	Yes 2 No
5	hysici nis cer i direci	To B	examiner? 1 ⊠ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	t 3 DOA	04	Home 5 Resid		(Specify) scene
5	ing PI		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. I	njury at Work?		ow injury occurred	
VISION	death death ctor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined.	110100	At home, farm, str		1 ☐ Yes 2 🖾 No	28f. Location (S	treet and Number	or Rural Route Number,
2	s after	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)				City or Town	n, State)	ANTON, MD
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. with Parenal Director: After this certificate hes been signed by the attending phy completely filled in by the funeral director, page 2 should be deteched for use as the	Medical ((Uneck only 212) Medical Exa	hysician: To the best of my	y knowledge, death	occurred at the	e time, date and pla	ce, and due to the c	ause(s) and mannate and place, an	ner as stated. d due to the cause(s)
	othe	Med	one) 29b. Signature and title of certifier	and manner stated.			ense number			Month, Day, Year)
	- > - 0		1 aux	31.		00	ME		January 1	9. 2006
4	VA		30. Name and address of person who		(Item 23a) (Type,	Print)				
	Sta	to	31. Date filed (Month, Day, Year)	32. R egistrar's S	Signature	111 Pe	enn Street	, Baltimo	ore, Mary	71and 21201
	Registr	- 1		2006	-					

				partment of Health and Mertificate of Death	lental Hygier	4000	03576
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ronald Leon Prickitt		2. Date of Death	006 Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death St. Michaels		4c. County of Dea Talbot	
	Funeral		205 Conner Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda.	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign
	Director		155-34-2076	Months Days Hours Min.	11-10-1	944 Top	oeka, Kansa
	Maryland f show	ō	10a. State 10b. County 10c. City, Town or Md Talbot St. Mic				10d. Inside City Limits 1 XYes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	s 23a		205 Conner Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	21663	anifu Van ar Na	USA 14. Race - Am	origan tadian
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examination intellies indiffed at	by Funeral	1 Never Married 2 Married 1 NYes 2 No	 Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto Yes 2X No Specify: 	Rican, etc.)	Black, Whi	te, etc.
5-0036	72 hour natural		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	. Kind of Business	/industry
2	within 7 iene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of worki DO NOT use retired)		onstruc	tion
<u>d</u> 21	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	nter 18. Mother's Name	e (First, Middle, Maid		
Maryland	should be nd Mental marked o	To B	Leon Phillips Prickitt		a Cain		
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Type, Print) Thelma C. Prickitt (mother) P.	iling Address (Street and Number or Rura O. Box 25, Clas			
Baltimore,	of He of He roth			position (Name of rematory or other place) 1 Crematory 1-2		Location - City or Over, D	
Balt	permit. Pag Department Important: I any injury o		A. Carroll Hughes	22. Name and Address of Facility R. Carroll Hur	_		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nte the mode of Byng, such as cardiac	S respiratory arrest,	aels,Md	• Approximate Interval Between Onset and Death
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DIVISION	Atjending It death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street	and Number or R	urat Route Number
2	ital or A irs after ral Dire		4 Homicide building, etc. (Specify)	,	City or Town, St.	ate)	
	To the Hospital or Atjandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dead of the best of examination and/or and manner stated.	ith occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner a and place, and due	s stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier M. Signature and title of certifier	29c. License number D 26388	TA	Date signed (Moni	2006
	-1=VA		30. Name and address of person who completed cause of death (Item 23a) (Type Michael Traddew MD	4	Her los	k md	21643
	Sta Registr	te	31. Date filed (Month, Pay Year) 6 2006 32. Regulars's Signature	Love			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert Newton Phillips January 10, 2006 2:06P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7620 Maple Avenue Takoma Park Montgomery Months Days Hours Min. April 10 a 30 a 1938 9. Birthplace (State or Foreign West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 67 577-50-5265 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Madical Examiner must be notified at 1X Yes 2 No Directo Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Maple Avenue 20912 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 No 1956— If Yes, Give Year or Dates: 1977 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ Specify: 3 ☐ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Hote1 permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygie Important: If item 27 is marked other to any Injury or other traumatic event. The 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newton Phillips Martha Simmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sirrell H. Phillips-daughter 1210 Bayard Street, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 1/20/06 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMcGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Diabetes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 2€ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) ٩ 1 XYes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and 14 29c. License number 29d. Date signed (Month, Day, Year) M 7A-MD426844 and address of person who completed cause of death (Item 23a) (Type, Print) 6900 Georgia Avenue, N.W., Washington, D.C. 20307 Andrew Cap, M.D. 31. Date filed (Month, Day, Year) 320 Registrar's Signature State JAN 20 2006 Registrar

		Ľ	for State Registrer	State of Maryland		irtment of H <i>tificate of L</i>			iene 19. No. 0 0 6) (03578
I	Physici		Decedent's Name (First, Middle, Last Ferinez	В.	Phel	DS		2. Date of Deat Month January	Day V	ar O	3. Time of Death 11:15P. M
	/Medic Examin		4a. Facility Name (If not institution, give 1014 Quaker Knoll			4b. City, Town, or	Location of Death Spring		4c. County of Montg	Death	
	Funeral Director		5. Social Security Number 6. Se 525-36-3262	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 10, 1	Year) 9 1922]	Birthpla Count EXA	ace (State or Foreign ry) S
	yland 10w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10	d. Inside City Limits
	Be-f sh	Director	Maryland Montgome:	ry :	Sandy	Spring					1 ☐ Yes 2 No
	th with the 23e or 23 List be n.	al Dire	10e. Street and Number 1014 Quaker Knoll	Road		10f. Zip Code 2086	60	1	Og. Citizen of Wha United S		•
036	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other then "neturel", or Items 23e or 28e-f show imatic event, Ite Marked Examiner and be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 ZNo If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, e	
21215-003	within 72 ho iene. Ithen "netui ine Medicel	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(GIVA	lent's Usual Occupa kind of work done of DO NOT use retired	turina most of work	ing	16b. Kind of Busin		,
	be filed withinal Hygiene. d other therevent, Ithe M	ø	17. Father's Name (First, Middle, Last) Anderson Michael	Brininstool			18. Mother's Name				
Maryland	should be nd Mental marked o	70	Anderson Michael 19a. Informant's Name/Relationship (7)	-	19b. Mailin	g Address (Street a				ite. Zip (Code)
	and 2 : ealth ar m 27 is ner treu		Claudia Phelps -da	aughter	7085	Wyndale S	Street, N	.W. Wash	ington,	DC 2	20015
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumstic evonce.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State Meta	netery, cren copoli	sition (Name of natory or other plac tan Crema	tory 1/1	9/2006		ia,	Virginia
Ba	permit Depar Impor eny in		21. Signature of Funera Se vice Licente		22 O 44	Name and Address nald V. E OO Powder	ss of Facility Borgwardt • Mill Ro	Funeral	Home, P	A arvl	and 20705
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition	lications that caused the death. ne cause on each line. a Chronic Obs	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					Ţ	
58760,	icate be executed physician and s the burial-transit	al Exai	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
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P.O. Box	or Attending Physicien: The law requires that the death certifitate death. Director: Atter this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal of 4□Pregnant at time of decentions 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		y Day Year
	w requires that been signed b should be deta	ed by Pt	Part II. Other significant conditions co Hypertension; Ata			nderlying cause give	en in Part I.		pacco use contribu es 2 □ No 3		e cause of death?
Vital Records,	The law re cate has being page 2 sho	Completed						24a. Was a autops perform	ned? pric	r to com	sy findings available opletion of cause of
Vita	sicien: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:	D/O-1	t 3E DOA Othe	26. Place of Deat				
	ng Phys fter this neral di	her	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	I Impatient 2 LE	28b. Time of Injury	I 3 DOA	4 Nuising Ho		ence 6 Other ow injury occurred	(Specify)	
Division of	Attendia death. ctor: A y the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Płace of Injury - At hor	ne, farm, str	M 1 []	Yes 2 □ No	28f. Location (St	reet and Number	or Rurai	Route Number,
2	itel or / irs after rel Dire		4 Romicide	building, etc. (Specity)				City or Town			
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	ledical	(Check only 2 Medical Exam	rsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	red at the time, d	ate and place, and	due to	the cause(s)
)	D with	Σ	29b. Signature and title of certifier	111		29c. License	25947		9d. Date signed (i January		
	1		30. Name and address of person who can Evelyn Jackson, M	ompleted cause of death (Item 1.D. 3416 O	^{23a)} (Type, .andwo	od Court	Olney, M	aryland	20832		
:	Sta Regist		31. Date filed (Month, Day, Year)	32. Pegistrar's Signate							

			For State Registrar	ite of Marylar		artment of H			ene)) 6 (3579
	Dhirelet		Decedent's Name (First, Middle, Last)					2. Date of Deatl Month	Day	Year	3. Time of Death
	Physicia /Medic		Theodore Allen	Rodg	ers			1	21	2006	10:22 amm
	Examin		4a. Facility Name (If not institution, give street a		. 1-		r Location of Death		3	ty of Death	1
				1cs - 291			Trappe		T		
	Funeral Director		5. Social Security Number 6. Sex 175 M 2	7. Age (In yrs. 7/	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 934	9. Birthpl Count Miss	ace (State or Foreign try) SOULI
1	pu »	}	Usual Residence of Decedent 10a. State 10b. County	100 Cit	ty, Town or Lo	action		,		10	Od. Inside City Limits
-6	Maryland	5		100. 0,	•						1 ☐ Yes 2 ☐ No
3	the M	ect	Maryland Talbot 10e. Street and Number			Oxford 10f. Zip Code		1/	Og Citizon of	f What Count	
\mathcal{Q}	with	Funeral Director	302 East Strand			216	554		og. Citizen o	USA	•
Se	ns 23	era		as Decedent Ever in U	l.S. 13.			ecify Yes or No-	14. Ra	ace - America	
0	r Iten	F	1 Never Married 2 Married 1	med Forces? ⊒Yes 2.⊒No	-	,	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		ack, White, e	
036	al', o	þ	3 ☐ Widowed 4 ☐ Divorced Ye	res, Give ar or Dates:		1□Yes 2☑No	Specify:		Spec	ity: Whi	ite
9	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	olete d)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of	Business/Ind	iustry
213	within ene.	npie		llege (1-4or 5+)	life.	DO NOT use retired	d)	ing			
21	ygien ygien yer th	S		5+	Manag	ement				acturi	L n g
힐	be fill H doth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			ime)	
38	ould Men Marka naric	٦°	Lee Roy Rodgers					Adele B			
a N	12 st h and 7 is n traun	9	19a. Informant's Name/Relationship (Type, Pr	•			and Number or Rura			n, State, Zip	Code)
o,	1 and Healt am 2 thar		Catherine Bitter/Spou 20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of	oxford		654 20c. Location	- City or Tox	wn. State
ō	nt of nt of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	al from State	cemetery, cre	matory or other plac	nCenter 01			•	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at one.		' 4 □ Donation 5 □ Other (Specify)	MI						- ,	
Ва	Dep.		William House Poly	mulle	1 N	lid Shore	ss of Facility Cremation on Rd., Ca	n Center	, P.O.	Box 1	1464,
		4	23a. Part1. Enter the disease, or complication	s that caused the dea						21013	Approximate
	Enysician		shock, or heart failure. List only one cau Immediate Cause (Final			`					Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	nuence of):	in 013	ease			-	12 month
	Examiner				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dresses of hije) that initiated events c	Due to (or as a consec	quence of):					1	
	cuted	Examiner	Cause (Disease or Injury that initiated events c								
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Bo	attend attend for us	ian	in the past 12 months?	Live birth 2 Feta Pregnant at time of	al death 3[☐Ectopic pregnancy ☐ Other (specify)	1			ate of delive Nonth	ry Day Year
P.O.	he de	Physician/Med		Unknown	ueatti 5t	Other (specify)					
م:	The law requires that the death certificate has been signed by the attending pt page 2 should be detached for use as t		Part II. Other significant conditions contributi	ing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to th	e cause of death?
ds.	uires n sign	d by	PARKINSON'S DISEA	EL				1 □ Ye	s 2 🗆 No	3 ☐ Proba	ably 4 Unknown
00	w require been si	lete		heuy-boo	he /-1	6.1		24a. Was a	n 24b	. Were autop	psy findings available
Re	The lav	Completed	- Emercial of pro-	000	1 91			autops	ned?	death?	npletion of cause of 2 No
ta	ician: T certificat rector, pa	0	25. Was case referred to medical				26. Place of Deat		No No	1 1 1 1 1 1 1 1	2 1 10
>	Physician: r this certificaral director,	To B	examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing Ho	me 5 Reside	nce 6 🗆 O	ther (Specify	<i>(</i>)
0	iding Physician: th. : After this certifica ; funeral director, p		27. Manner of Death 1 Salatural 5 Pending	a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor		28d. Describe ho			
Sio	2 2 2 2	catio	2 Accident investigation			M 1	Yes 2 □ No				
Division of Vital Records,	al or Attandii s after death. al Diractor: Al	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	 Place of Injury - At h building, etc. (Speci 	nome, farm, st ify)	reet, factory, office		28f. Location (St. City or Town		nber or Rura	l Route Number,
	urs a		29a. Certifier 1 Certifying Physician	- T- N 1 1 1 1							
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examiner: C	on the basis of examinated manner stated.	ation and/or in	nvestigation, in my o	me, date and place, ppinion, death occur	red at the time, di	ause(s) and r ate and place	nanner as st e, and due to	the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	- \		29c. Licens	4	2	9d. Date sign	ned (Month, L	Day, Year)
			De alle Well.	mD		D40	0274		1/	23/2	00 C
			30. Name and address of person who complete	ed cause of death (Ite	т 23а) (Туре	, Print)	-				
			I. Allen Webb, M.D	8579	Com	nerce Dir	#106. EAS	MN, MD	2160	5/	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 200	6 32. Registrar's Sign	ature	Sports					

			1 - State of Maryland / Dep	ertment of Health and ertificate of Death	Mental Hygie	
	Dhorisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medio		Herman Lee Rogers			28 2006 10:00AM M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death Caroline
			9071 Legion Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Denton (i) If Under 1 Year If Under 24 Hr	rs. 8 Date of Birth	
	Funeral Director		225-24-3956 1 X 2 F 81 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) Virginia
	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	•	10d. Inside City Limits
	Maryli f eho	ō	Maryland Caroline Denton			1 ☐ Yes 2 K No
	r 28a	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	th with	al D	9071 Legion Road	21629	Un	ited States of Americ
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Marical Examiner must be rediffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give 14 Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 【 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	2 hour atural			edent's Usual Occupation	16	Caucasian b. Kind of Business/Industry
21215	within 72 iene. than "ne he Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) rpenter		Home Builder
ב	e filed Il Hygie other	BeC	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma.	
<u>Iar</u>	should be and Mental I marked o	ToB	James Willie Rogers	Lo1	la Watson	
Maryland	and and is m		11 C 1 T D 11 F -	ling Address (Street and Number or F		
	1 and Health		70/1	Legion Road, Der		and 21629 c. Location - City or Town, State
ē	Pages ent of nt: if i		X Abuilai 2 Cigination 3 Cinemoval nom State		2/2006 Hi	llsboro, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar					on, Maryland 21629
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure List only one cause on each line.	nter the mode of dying, such as cardi	ac or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	heart Fai	1,00	Onset and Death
	/Medical Examiner		resulting in death) Due to or as a consequence of):	- COO D	lure ease	10013
		er	Sequentially list conditions, if any, leading to immediate b. Oras a consequence of):	rlery Disc	ease	years
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Ö,	e exec ien an urial-tr		resulting in death) Last Que to (or as a consequence of):	7,1.00		YC4.
68760	licate be executed physicien and s the burial-transit	edical	d			
ox e			FFEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
n	a death he ette ed tor	Physician/M	in the past 12 months? 1 Yes 2 No 1 No	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
0	res that the de signed by the e be detached t	Phy	9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobac	cco use contribute to the cause of death?
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000	law requira as been si 2 should b	Completed			24a. Was an	24b. Were autopsy findings available
ř		Com			autopsy performed	prior to completion of cause of death? No 1 Yes 2 No
Vita	ician: sertitic ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	eath (Check only one)	
ō	Attending Physician: or death. actor: After this certific by the funeral director,	To	1 ☐ Yes 2 ☐ No ☐ 105 Ptal: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		Home 5 Residence	e 6 Other (Specify)
on	nding lath. r: After e funer	atlor	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No		
Division	il or Attendi atter death. Diractor: A	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	spital o	0	29a. Certifier **Certifying Physicien: To the best of my knowledge, dea			
	To the Hospital or A within 24 hours atter To the Funeral Dirac completely tilled in by	edical	29a. Certifier Secretifying Physicien: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
			James Jestes M	D31376		-30-06
			30. Name and address of person who completed cause of death (Item 23a) (Type		0.0	
	Sta	te	James Sides, M.D., PO Box 496, Dent	on, Maryland 216	29	
	Registr		JAN 0 1 2006	20		

		1 - For State Registrar	State	of Marylar	nd / Depa	artment of tificate o	Health of Death	and M		giene Reg. No		03581
		Decedent's Name (First, Middle, I	_ast)						2. Date of De	ath		3. Time of Death
Physic		John E. Rees	e						Month Januar	Da v 21	y Year 1, 2006	7:10 a ^M
/Med Exami		4a. Facility Name (If not institution, g		umber)		4b. City, Town	n, or Location	of Death			. County of Dea	
		9107 Good Luck F	load			Lanham	1			Pı	rince Ge	eorge's
Funeral			Sex	7. Age (In yrs.		If Under 1 Ye Months Da		Min.	8. Date of Birt (Month, Da	v. Year) Co	thplace (State or Foreign
Director		213-38-0392	1⊠M 2□F	65	Yrs.				Nov. 10), 1	940 Was	hington, DC
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
Maryi fehc	0	Maryland Prince	Coorgo	a I ar	nham							1 X Yes 2 ☐ No
the 288	rec	10e. Street and Number	George	5 Lai	IIIaiii	10f. Zip Cod	е			10g. Ci	tizen of What Co	ountry?
3a or	Funeral Director	9107 Good Luck R	oad			20706				U.S.	Δ.	
death ms 2	Jera	11. Marital Status	12. Was De	edent Ever in U	J.S. 13.	Was Decedent	of Hispanic Or	rigin? (Spe	city Yes or No		14. Race - Ame	
or Its		1 ☐ Never Married 2 💢 Married	Armed F 1 Tes If Yes, G	2 🔀 No		f Yes, specify C 1 □ Yes 2 🗓 I			Hican, etc.)		Black, Whit	
Sours First	dby	3 Widowed 4 Divorced	Year or			TU Tes ZIALI	чо зреспу.				Specify: T	√hite —————
72 h	Completed	15. Decedent's (Specify only highest)	(Give	dent's Usual Oc kind of work do	ne durina mos	st of workin	ng	16b. K	(ind of Business	/Industry
Mithir Militin	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)	Mecha	DO NOT use rei	irea)			0	Dugina	
Hygie Ther		17. Father's Name (First, Middle, La	st)		песна	птс	18. Moth	er's Name	(First, Middle,		n Busine	:55
at yiellid AIAID-UUDO should be filed within 72 hours after death with the Maryland nd Mental Hygiene. nmarked other than "natural", or Items 23a or 28a-1 ehow umatic event, the Medical Examiran must be incitiad at	Be	Edward Reese							nelia B			
Should Me	5	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stre					or Town, State,	Zip Code)
ING od 2: dith ar 27 to		Charlotte E. And		e: Wife							yland 20	
S 1 a		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of			ate		ocation - City or	
Page ento		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1 State				01/25	5/2006	Brei	itwood.	Maryland
Dattilliore, Interylation ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinant must be incitited at once.		21. Signature of Funeral Service Liv	ensee/								al Home	
		allen line	10 51	10137								MD 20781
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that	caused the deal	th. Do not ent	er the mode of	tying, such as	s cardiac o	r respiratory ai	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			tar.	non	- Smc	11 Ce	يرنا لا	0	-16	Onset and Death
/Medical		resulting in death)	Due to	(or as a consec	quence of):)		
Examiner		Sequentially list conditions,	b									
be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):							
xecut and i-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
cate be executed physicien and the burial-transit	<u>a</u>											
ficate	edical		d							-		
ath cert	Z	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Totale areas					23d. Date of de	livery
w requires thet the death certifications igned by the attending should be detached for use es	Physician/M	in the past 12 months?		mant at time of		Ectopic pregna Other (specify					Month	Day Year
by the	hys	9 Unknown										
es the	à	Part II. Other significant condition	s contributing to	death but not res	sufting in the u	nderlying cause	given in Part	l.				the cause of death?
law requires law seem signer as been signer 2 should be	ted								14	Yes 2	No 3 P	robably 4 Unknown
Physician: The law requires that the death certificate has been signed by the attending rethic cock, page 2 should be detached for use es	Completed								24a. Was autor	SV	prior to	utopsy findings available completion of cause of
The cate h	Co									rmed? 2 □ No	death?	2 □ No
VICAL Ician:] certifical ector, p	96	25. Was case referred to medicat examiner?	Hospital:			1			(Check only o			
Phys this	7	1 ☐ Yes 2 Ø No 27. Manner of Death	1	Inpatient 2	ER/Outpatier 28b. Time of				ne 5 Residente la		6 Other (Spe	icify)
ding h. After	fon	1 Natural 5 ☐ Pending	(Mo	nth, Day Year)	Injury	1	njury at Work? ☐ Yes 2 ☐		od. Describe i	IOW III II	ily occurred	
Attending or death. Atter ector: After by the fune	flca	3 ☐ Suicide 6 ☐ Could no	be One Die	e of Injury - At h	nome, farm, str				28f. Location (Street a	nd Number or R	ural Route Number,
d in b	Certification:	4 Homicide		ding, etc. (Speci		,			City or To	vn, Stat	Θ)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To the	ne best of my kno	owledge, deatl	occurred at the	e time, date ai	nd place, a	and due to the	cause(s	and manner a	s stated.
the H in 24 the F	ledical	one)	and ma	nner stated.	attori attoror itt			alli occure	od at the time,			
. 5 til 5 ti	Σ	29b. Signature and title of certifier					ense number				ate signed (Mon	
					- 00 : =	D50	686			Jan	uary 24	, 2006
(5)		30. Name and address of person will Gurdeep S. Chhab					Lane #	123.	Rowie	MD	20715-4	031
S	tate	31. Date filed (Month, Day, Year)					HAIIE #	1239	DOWLES	ш	20/13-4	OJ1
Regis		JAN 2 4 200	S Sie	Registrar's Sign	Brank	Ø)						

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

P.O. Box 68760.

of Vital Records,

32. Registraria Signature

2006

			1 - For State Registrar	State of Maryla			nt of Healt te of Dea			jiene	6	03583
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Yeer	3. Time of Death
	Physici /Medic		CLEONA S. ROSS			т			JANUAR'	Y 21, 2	2006	7:30P M
	Examin	er	4a. Facility Name (If not institution, give st		T A TD	4b. City	, Town, or Locat CLINTO				y of Death	GEORGES
-	Funeral		BRADFORD OAKS NUR 5. Social Security Number 6. Sex		nAD rs. last birthday)		er 1 Year If Ur	nder 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
в	Director		579 26 4796 1 ¹	м ЖХғ	93 Yrs.	Months	Days Hou	urs Min.	JUNE 12	, 1912	WASI	HINGTON, DC
	pu .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or L	ocation						10d. Inside City Limits
	Manyle f sho	or	MD PRINCE GE		EMPLE H							XX Yes 2□No
	r 28a	Irec	10e. Street and Number			10f. Z	ip Code		1	0g. Citizen of	What Cour	ntry?
	23a o	al D	4003 24TH PLACE				20748			UNITEI	STAT	res
	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at	Funeral Director		2. Was Decedent Ever in Armed Forces?	u.S. 13.	Was Dec If Yes, sp	edent of Hispanio ecify Cuban, Me:	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ack, White,	
35	Ir, or	by F	1 ☐ Never Married 2 ☐ Married *** Widowed 4 ☐ Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:		1 ☐ Yes	XX No Spe	ecify:		Speci	ty: BLA	ACK
ခို	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Us	ual Decupation	most of worki	ing	16b. Kind of E	Business/In	dustry
21215-0036	ithin 7 9e. Nen "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	most of work	-			
2	e filed within al Hygiene. I other then " vent, the Me		12TH 17. Father's Name (First, Middle, Last)			CLI		Anther's Name	e (First, Middle,	-		OF DEFENSE
au	Mental I	To Be	WYNTER JOHNSON					UBY HU				
Maryland	E E E	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ing Addre	ss (Street and No	umber or Rura	al Route Numbe	r, City or Towr	n, State, Zip	Code)
	1 and 2 Health a ism 27 is		JOHN F. ROSS / SO				H PLACE	TEMP	LE HILL	s, MD 2	20748	
altimore,	Pages 1. nent of He int: If itsn iry or oth		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Re		o. Place of Disponentery, cre			1	Date	20c. Location	- City or To	own, State
ti m	t. Pag tment rtant: njury o		' 4 □ Donation 5 □ Other (Specify)	L]			IAL CEM			SUITLA		
Ba	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service License	000	2		SHALL S SUITLA		L HOME	OF MARY	LAND	,INC.
	/Medical Examiner bulksicien and step physicien and	l Examiner	Immediate Čause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con: Due to (or as a con:	sequence of):	7C	CANE	XOUA	CIAR	DISG	318	Onset and Death
68760,	ificate b g physic as the b	edical	d.							1		
.O. Box	that the death certific ted by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown	Sc. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic □ Other (pregnancy specify)				ate of delivers	ery Day Year
ds, P	Se Dig	by	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying	cause given in F	Part I.		bacco use cor		he cause of death?
Records,	w requir been sl	Completed							24a. Was a	an 24b.	Were auto	opsy findings available
Re	The lav ate has page 2	ошо							autop. perfor	sy	prior to co death? 1 \(\text{Yes} \)	empletion of cause of
Vita		O	25. Was case referred to medical				26. I	Place of Deatt	1 ☐ Yes h (Check only or			2010
of V	di S	ToB	examiner? 1 ☐ Yes 2 No	ospital: 1 🗌 Inpatient	2 ☐ ER/Outpatie	nt 3□ l		Nursing Ho	me 5 Resid	ence 6 🗆 Ot	ther (Specia	fy)
onoi	ding h. After fune	atlon;	27. Manner of Death 1 Katural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time (njury	of M	28c. Injury at Work? 1 ☐ Yes		28d. Describe h	ow injury occu	ırred	
Division	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	t home, farm, s ecify)	treet, facti	ory, office		28f. Location (S City or Tow		ber or Rur	al Route Number,
	e Hospital or At 24 hours after of e Funeral Direct letely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurre	ed at the time, da on, in my opinion	ite and place, i, death occuri	and due to the or red at the time, or	cause(s) and materials	nanner as s , and due t	itated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				9c. License num			29d. Date sign		
			30. ame and address of person who co		>		D-(87	. YS	J.	ANUNA	y 2	2, 2006
_	(5)		30. ame and address of person who co	mpleted cause of death (Item 23a) (Type	Print)	1118 19	w 150	11120	DOF.	Mdd	. ZE(0)
		110	31. Date filed (Month, Day, Year)	2. Registrar's S	ignature -	، رب	7100 -2	JUC		100		
	St Regist	ate rar	JAN 2.5 2006	2. Registrar's S	k La	Bi						

			For Stete Registrer	State of Maryland		rtment of			giene Reg. No.	006	0358	1,
Ï	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of De	ath
	/Medic			ATTHEW RODRIQU	ÆZ			Januar	4 21	2006	18:24	М
	Examin	ner	4a. Facility Name (If not institution, give st	treet and number)	/	4b. City, Town,	or Location of De	ath	/ 4c. 0	County of Death	1	
	· ·		5: Social Security Number Nave 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	MORC If Under 24 H	rs. 8. Date of Bir	th	9. Birth	place (State or Fo	oreian
	Funeral Director			M 2□F	Yrs.	Months Days	Hours Mi				place (State or Fo intry)	
	D.		Usual Residence of Decedent					Jan 20	, 200	υ Ψai	ryland	
	how	_	10a. State 10b. County	,	Town or Lo		-	_			10d. Inside City L	
	80-1-08	Directo	Maryland Harfo	rd			avre de (Grace				
	with ti	直	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	death with the Maryland rme 23e or 28e-f ehow rmust be notified at	erai	422 Battery 11. Marital Status	Drive 2. Was Decedent Ever in U.S.	13. V	Nas Decedent of	21078	(Specify Yes or No	h- 1:	USA 4. Race - Amer	ican Indian	
20	s 1 and 2 should be filed within 72 hours after death with the Marylan it Heelth and Mental Hyglene. Item 27 is marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funerai	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cull IXYes 2☐ No		(Specify Yes or No erto Rican, etc.) erto Rica		Bfack, White		anic
ş	2 hou		15. Decedent's Educ	ation	16a. Deced	lent's Usual Occu	pation			d of Business/li	ndustry	
2	within 7; ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0·12)	completed) Coflege (1-4or 5+)	(Give life. L	kind of work done DO NOT use retin	during most of weed)	vorking				
7	giene giene	등	0	conego (1 to, ot,		Neve	Worked					
2	ai Hy ai Hy 1 oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden S	Sumame)		
<u>X</u>	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Mental count, the Mental count coun	ဥ	Catalino Rodrique	Z				yl Lynn F				
ar	2 sh and ie m		19a. Informant's Name/Relationship (Typ					Rural Route Numb				
e o	of Heelth of Heelth in Item 27 i		Cheryl Phippin / m 20a. Method of Disposition	The state of the s		Battery sition (Name of	Drive, H	lavre de		Mary Mary		78
E			1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, cren	natory or other pla	· 1					
	permit. Page Depertment of Important: if any njury or once		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			. Name and Addr	Cem. 1/	30/06	Havr	e de Gr	ace, MD	_
n n	Depuil Important		21. Signature of Purioral Solvice Licenses) Cit		Lįsa S	Scott_Fur	neral Hom et, Havr	e, P.	Α.		_
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one finmediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line. EXTREME Due to (or as a conseque	Do not enter REN nce of):	er the mode of dy	ing, such as card	ac or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	en
,00/0	ate be executed hysicien and the buriat-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		int_ i	ubre	hemi	dericz w		1014	
×	certificate iding phys ise as the	/Me	IF FEMALE:	lc. If yes, outcome of pregnance	·v				0	Od Dovo of dollar		
O. BOX	death e atter id for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3□	Ectopic pregnant Other (specify)	су		2.	3d. Date of delik	∕ery Day Yea	ır
ras, r	requires thet the een signed by th nould be detache	5	Part II. Other significent conditions conf	ributing to death but not result	ing in the ur	nderlying cause g	iven in Part I.	23e. Did 1			the cause of deat	
ဝ၁		Completed						24a. Was		24b. Were aut	opsy findings ava	ulable
ľ	rsician: The law s certificete has t lirector, page 2 s	E						auto perfe	ormed? 2 No	death?	ompletion of caus	ie or
<u>ro</u>	rifice	BeC	25. Was case referred to medical				26. Place of D	eath (Check only			10.11	
<u>></u>	Physician: this certific ral director.	2	examiner? 1 Yes 2 No		R/Outpatien	t 3 DOA	ther: 4 🗌 Nursing	Home 5□Resi	dence 6	□Other (Spec	ity)	
0	ding Phys		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of fnjury	28c. Inju	ury at ork?	28d. Describe	how injury	occurred		
<u>s</u>	Attending I ar death. ector: Atter by the tuner	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No					
DIVISION	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: After completely tilled in by the funer	Certification:	4 Homicide determined	28e. Pface of Injury - At hom building, etc. (Specify)				City or To	wn, State)		ral Route Number	
	Hosp 24 hou Fune tely til	edicai	29a. Certifier (Check only one) 1	icien: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the restigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	o the ithin (o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date	signed (Month	, Day, Year)	
	⊢ 3 ⊢ ŏ		Flun	RAUL CHAV	EZ-V	DITES 15	ES-000		Pani.	1 2	The same	5
			30. Name and address of person who con	npleted cause of death (Item 2	F <i>ELLC</i> 23a) (Type.	Print)			Jones	mj: 2	, , 2000	
			RAUL CHAVEZ-VALE	JEZ 600	N. L	DOIFE S	tract.	BAHIMO	10.11	MARY LAI	1 2128	7
	Sta		31. Date filed (Month, Day, JAN 2 6	RAUL CHAN REST DOC Inpleted cause of death (Item 2 32. Registry's Signature 2006	re 🖟	Brest.	,		,	7	-	
	Registi	reli.	20	THUM I MANAGEMENT	1	The same of the sa						

			1 - For State Registrar	State of Maryl		artment o			Reg. No.	03585
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
1	/Medic	al	John T. Robinso 4a. Facility Name (If not institution, give s			4b City Tow	n, or Location of D	Januar	y Z1 Z006 4c. County of Dea	6:16 AM
*	Examin	er	Southern Mary		tal	45. Ony, 1011	Clinto		,	e George's
	Funeral)B	Social Security Number 6. Sex	7. Age (In)	rs. last birthday,	If Under 1 Ye Months Da			th 9. Bir	thplace (State or Foreign
-8	Director			M 2∐F	71 Yrs.	WIOTHING DO	73 110013	Aug. 2	5, 1934 Sou	th Carolina
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh	tor	Maryland Prince Go	eorge's			Clinton	1		1 TYes 2 □ No
	or 288	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of What Co	,
	s 23a	rail	9106 Pine View				2073		United	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 		Was Decedent of Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)		
5	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Oc	ne during most o	f working	16b. Kind of Business	/Industry
12	within ane. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	_{tired)} ra1 Emp1	OVER	Govern	ment
9	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)			reac		Name (First, Middle		merre
an	Ald be Alental rked o	To Be	Thomas A. Rol	binson				Mary	M. Woodberr	У
lary	and h		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Maili	ing Address (Str	eet and Number o	or Rural Route Numb	er, City or Town, State,	Zip Code)
<u>ک</u>	l and lealth im 27 ther tr		Alberta McMillar 20a. Method of Disposition		201 b. Place of Disp			Wash., DC	20020 20c. Location - City or	Town State
וסר	ages nt of the : If ite		1 XBurial 2 ☐ Cremation 3 ☐ Re	omount from State	cemetery, cre	matory or other	Park 1/		Landove	
틀	artme ortani injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	~			Idress of Facility		t Funeral H	-
ã	Den Part Part Part Part Part Part Part Part		bolin I.	Derman 1		400	1 Bennin	ng Rd., N.	E. Wash., D	C 20019
	Pnysician /Medical		23a. Part1. Ertar the disease, or complic shock, of heart failure. List only on Immediate Ca. le (Finat disease or condition resulting in dea h)	e cause on each line.	Myo care	1 1 1	dying, such as ca		rrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	Sequal So of).					Acid to
P.O. Box 6	death certifi e attending id for use as	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregna □ Other (specify			23d. Date of de Month	livery Day Year
	law requires that the de es been signed by the a 2 should be detached	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause	given in Part I.		tobacco use contribute to Yes 2 <mark>⊡</mark> no 3 □ P	o the cause of death?
Vital Records,	The lav ate hes page 2	Completed						24a. Was auto perfe 1 Yes	san 24b. Were all prior to death?	utopsy findings available completion of cause of
<u>Zita</u>	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Death Check only	one	
	S D	tion: To	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. I	Other: 4 Nursi	28d. Describe	idence 6 □Other (Spe how injury occurred	ecify)
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - A building, etc. (Sp.		reet, factory, off	ice		Street and Number or R wn, State)	ural Route Number,
	he Hospitai in 24 hours a he Funeral I pletely filled	edicai	(Check only 2 Medical Examin	ner: On the best of my ner: On the basis of exam and manner stated.	nination and/or in	rvestigation, in n	ny opinion, death	occurred at the time,	date and place, and du	e to the cause(s)
	To the vithin 2 to the complet	Σ	29b. Signature and title of conflier	1: 2		29c. Lic	ense number		29d. Date signed (Mon.	th, Day, Year)
	(4)		1 1 100000	mi		D	00351	10	JAMUARY ?	23 2006
	A.C		30. Name and address of person who con	mpleted cause of death of 132 \$ Journal of 132. Referrar's \$	Item 23a) (Type	Print)	A 210	washing to	DC 20001	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Red strar's S	anuli	40 40	3/0		/ -	
F	Regist		JAN & D ZUUD	-						

			1- State of Maryland / Department of Health and Mer Certificate of Death	Reg. I	43 W W W	03586
	Physici /Medio		BYRON CILYSSES KOSS	Date of Death Month TANK 2	Day Year 7 2006	3. Time of Death /2:05 A: M
	Examir	ner	Months Days Hours Min.	Date of Birth (Month, Day, Yea	ar) Cour	lace (State or Foreign
	Director	or	Usual Residence of Decedent 10a. State 10b. County , 10c. City, Town or Location	Tuly 6,1		Od. Inside City Limits 1 Des 2 □ No
	h with the M 3s or 28s-f st be natifie	al Director	MO. FREDERICK FREDERICK 100. Street and Number 436 HEATHERI day DR. 11702	10g. (Citizen of What Cour	ntry?
036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ehow ta Medical Examinar maial be mullied at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica If Yes, Specify: 1 Never Married 2 No If Yes, Give Year or Dates:	/ Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: BLA	
21215-0036	d 2 should be filed within 72 hours th and Mental Hygiene. ?? Is marked other than "natural", traumatic event, Ir a Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAH TECHNICIAN	16b.	Kind of Business/Inc U. S. GO RT DETI	dustry VI
Maryland	2 should be filed and Mental Hygis is marked other raumatic event, iii	To Be C	17. Father's Name (First, Middle, Last) CHARICE ROB(NSON) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Foral Re	i Ro	55	0-4-)
	es 1 an of Heal of Item 2 or other		TANE ROSS WIFE H36 HEATLERINGE DATE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date	e. 1968	Location - City or To	4702 wn, State
Baltimore,	permit. Pag Department Importent: t any injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility GAR. 10 W. South ST. F.			scrac Hore
Distance.	Physician /Medical Examiner	er	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	spiratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examine	cause. Enter Underlying Chise Trises of the property of the pr			
.O. Box 6	at the death certific by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delive Month	ry Day Year
S, O	The law requires that the tee has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to th	e cause of death? ably 4 ∐Unknown
Vital Record		e Completed	25. Was case referred to medical 26. Place of Death, Cl.	24a. Was an autopsy performed? 1 Yes 2 1	prior to cor death?	osy findings available inpletion of cause of
ō	ng Physic ter this ce neral direc	atlon; To B	To Natural Solution Pending Content of Death Accident Investigation Pending Content of Death Investigation Pending Content of Death Content of		6 Other (Specify occurred	')
Division	Hospital or Attendir 24 hours after death. Funeral Director: Al tely filled in by the fu	il Certification;	4 Homicide building, etc. (Specify)	City or Town, Sta		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and consider the time, date and place, and eath occurred a and manner stated. 29b. Signature and title of certifier 29c. License number	t the time, date a	nd place, and due to eate signed (Month, I	the cause(s) Day, Year)
0	HVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1/	26/200	21702 C MD
9	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2006 John Man A Signature	by K	VEDENICI	C MD

		1- State Registr Amend Item	#10e Per IN	IF G852	2916/6	te of	Death			eg. No.	0	03307
Physic	an	Decedent's Name (First, Middle, L.	ast)						2. Date of Dear Month	th Day	Year	3. Time of Death
/Medi		LILLIAN			RUMERMA				JANUARY			6:40 P
Exami	ner	4a. Facility Name (If not institution, g			4b. Cit	y, Town, o	r Location o	of Death		4c. Count	y of Death	h
		HEBREW HOME OF G 5. Social Security Number 6.			helous) If Lind	RO er 1 Year	CKVIL If Under		O. Data of Birth			GOMERY
Funeral Director		059-40-5795	1 M 2 XF 7. Age) (In yrs. last birti 92 Y	rs. Months		Hours	Min.	8. Date of Birth (Month, Day, 08/27/19	Year)	Co	hplace (State or Foreign untry) POLAND
		Usual Residence of Decedent				1		1 3	00/2//1	/13		TOLAND
yland how		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
e Ma	cto	MARYLAND M	ONTGOMERY		F	ROCKV	ILLE					1X Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Estarilizat must be neithed at once.	Funeral Director	10e. Street and Number 199 R	ollins Ave.	Apt 7	18 10f. Z	ip Code			1	0g. Citizen of	What Co	untry?
ath w	ral	6121 MONTROSE RO					2085				S.A.	
tems	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec If Yes, sp	edent of H ecify Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		ce - Amer ick, White	ncan Indian, e, etc.
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	lo	1 ☐ Yes	2 ∑ No	Specify:			Speci	y: WH	ITE
hour tural	edt	15. Decedent's	Year or Dates:	16a	Decedent's Us	ual Occup	ation			16b, Kind of 8	Business/l	Industry
in 72 n n	Completed	(Specify only highest g	rade completed)		(Give kind of w life. DO NOT	rork done	during mos	t of worki	ng	TOD. INITIO OF E	, , , , , , , , , , , , , , , , , , , ,	in outly
with jene.	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	HC	MEMAI	KER			OWN HO	MF	
Hyg other	Be C	17. Father's Name (First, Middle, Las	st)	<u> </u>	110			er's Name	(First, Middle, I			
nd 2 should be file ith and Mental Hy 27 is marked oth fraumatic even!	To B	SOL	RU	MERMAN			YETT	A			LAZ	AROFSKY
shou ind N	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ss (Street	and Numbe	er or Rura	il Route Number	, City or Town	, State, Z	ip Code)
alth a		MELVYN RUMERMAN/	SON	100	D17 COL	EBRO	OK AV	ENUE	, POTOMA	C. MAR	YLAN	D 20854
La Harage		20a. Method of Disposition		20b. Place of		ame of				20c. Location		
permit. Pages 1 a Department of Hee Important: If item any injury or othe ance.		Magazial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec						01/20	0/2006	XON HI	LL.	MARYLAND
permit. Departn Imports any inju		21. Signal ray X Funeral Sarvice oc	ensee	<u> </u>					L DIRECT			
88 58		COMMUN			1091 R	OCKV	ILLE	PTKE.	ROCKVI	I.I.E. M	ARVI.	AND 20852
		23a. Part I. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do n								Approximate Interval Between
Enysician		Immediate Cause (Final disease or condition	A	1970	tenesis							Onset and Death
/Medical		resulting in death)	Due to (or as a	a consequence o								
Examiner		Sequentially list conditions	b									
₽ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury		consequence o	f):							
acute ind trans	Examiner	that initiated events resulting in death) Last	c									
be executed ician and burial-transit	Ě	resuming in Geath) Last	Due to (or as a	a consequence o	t):							
ys e	dicai	•	d				·				-	
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE:	22a If you cutooma	of prognancy								
ath c	ian	23b. Was decedent pregnant in the past 12 mgnths?	23c. If yes, outcome of	2 Fetel death	3 □Ectopic		,				ate of deli onth	very Day Year
the a	ysic	1 ☐ Yes 2 ☑ Ño 9 ☐ Unknown	4□Pregnant at i 9□Unknown	time or death	5 Other (s	sреспу)						
that the	F.	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlyina	cause div	en in Part I		23e. Did to	bacco use cor	tribute to	the cause of death?
sign d be	5	CINIFF	colitis			-			1 □ Y	es 2 🗆 No	3 ☐ Pro	obably 4 Ethknown
w require been si should I	ete	0/ /	11						040 1160	- 1045	Man	to a subject of the s
e law	I d	Pleuvil el	fusions						24a. Was a autops perfori	sy	prior to death?	topsy findings available completion of cause of
n: Th icate r. pag									1 ☐ Yes	2 DNO		2 🗆 No
ricier certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Oth	-	and the same of the same of	(Check only on			
ding Physicien: The lav h. After this certificate has funeral director, page 2	5. To	1 Yes 2 No	1 ∐ Inpatier	nt 2 ER/Out y 28b. T					me 5 Reside			cify)
or Attending Physicien: The law requires tater death. Silector: After this certificate has been signed in by the funeral director, page 2 should be to	tion	1 ☐ Natural 5 ☐ Pending	(Month, Day		jury	28c. Injur Wor	k? Yes 2 🔲		EDG. DOGGNEG III	314 II QUI 3		
Attending ir death. ector: After by the funer	fica	3 ☐ Suicide 6 ☐ Could not	be an Place of Inju	ırv - At home, far					28f. Location (Si	treet and Num	ber or Ru	ıral Route Number,
lor A after Dire	Certification;	4 Homicide determine	building, etc	. (Specify)	.,	.,,			City or Town			
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying I	Physicien: To the best o	of my knowledge.	death occurre	d at the tin	ne, date an	nd place.	and due to the c	ause(s) and m	anner as	stated.
e Ho 24 h e Fur	edical	(Check only 2 Medical Exone)	eminer: On the basis of and manner sta	examination and	or investigation	n, in my o	pinion, dea	th occurr	ed at the time, d	ate and place	and due	to the cause(s)
orthin compl	Me	29b. Signature and title of certifier	~		2	9c. Licens	e number		2	9d. Date sign	ed (Month	h, Day, Year)
- > - O		1 1 h	Willi-	mo.		26	525	3	¢,	T	. 14	2 10000
6		30. Name and address operson wh	o completed cause of de	eath (Item 23a) (Type, Print)					JUNNUL	4 1	u. We
		Gary B. W.	1ks .mg	6 (2 (mont	الإن زاده	Ros	1	Rocko	11- m	D 2	10852
Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1	0						
	rar	JAN 20	2006 Marie	J. J	6000ACL	7						

			1 - For State Registrar	State of Ma	-	artment of H		nd Mental Hy	giene	5 0	3588
	Physici /Medic		1. Decedent's Name (First, Middle, L Marcia	ast)	oserth	a 11		2. Date of Dea Month JANUARY		Year	3. Time of Death $16:55 ^{M}$
	Examin		4a. Fecility Name (If not institution, g	WAY			ETHESI	DA		TGOME	
	Funeral Director		5. Social Security Number 6. 071-54-1115 Usual Residence of Decedent	. Sex 7. Age 1	(In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Birt (Month, Da JULY 29	v. Year)	9. Birthplac Country NEW	
	Maryland I-f show	tor	10a. State 10b. County MARYLAND MONTGOM	1ERY	10c. City, Town or Lo	cation BETHE	SDA			100	I. Inside City Limits 1 X Yes 2 □ No
	with the	Direc	10e. Street and Number	TIAY		10f. Zip Code	0817		10g. Citizen of W	hat Country	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel; or Items 23a or 28a-f show eumatic event, the Medical Executar prints by rodified at	by Funeral Director	7911 QUARRY RIDGE 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	0		ispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black	- American , White, etc.	Indian,
Maryland 21215-0036	vithin 72 hounder.	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most 1)		16b. Kind of Bus		
nd 2	fillad Hygi other ent, I	Be Co	17. Father's Name (First, Middle, La	4 st)	EXE	CUTIVE DI		K 's Name <i>(First, Middl</i> e,			NGLE BID
ızlaı	should b nd Ments markad matic e	Tof	RABBI WILLIAM A. 19a. Informant's Name/Relationship		19b. Mailir	na Address (Street		OSTROWER or Rural Route Number	ar, City or Town, S	State, Zip C	ode)
	and 2 sealth ar n 27 is		IRENE O. ROSENTHA		14 S	USSEX ROA		ARLESTON, S	SOUTH CAR	ROLINA	A 29407
nore	ages 1		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			matory or other plac		Date 1/23/2006	20c. Location - C		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic evunter		21. Signature of Funeral Service Lic		nyer 1	2. Name and Addres DWARD SAG	ss of Facility	NERAL DIREC	CTION,ING	C. ARYLAI	ND 20852
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a SELF-INI		ter the mode of dyin	ig, such as o	cardiac or respiratory a		A I	Approximate Interval Between Onset and Death
8760,	Examine be executed bhysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a	a consequence of):						
O. Box 6	The law requires that the death certificate at a has been signed by the attending physpage 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy	1		23d. Date Mon	of delivery	ay Year
ds, P.	uires that signad b Id be deta		Part II. Other significant conditions	contributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contri res 2√√No :	bute to the	
Division of Vital Record	The law requir ata has been s page 2 should	Completed						24a. Was autor perfo	osy pr rmed? de	ere autops rior to comp eath? Yes 2	y findings available pletion of cause of
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital:	nt 2 ER/Outpatier	nt 3□ DOA Cth	05	of Death (Check only of Sing Home 5 XResid		r (Specify)	
ion of	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injun (Month, Day)	y 28b. Time o Year) Injury	f 28c. Injur Wor	y at	SELF-IN	TÜÜTED"		HOT WOUND
Divis	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Certification:	X Suicide 6 ☐ Could not determine	28e. Place of Inju building, etc	ry - At home, farm, str . <i>(Specify)</i> HOME	reet, factory, office		28f. Location (: 701 Ty %)	Street and Numbe		Poute Number, Y, POTOMAC
	e Hosp 24 hou e Fune letely fil	edical		Physician: To the best o aminer: On the basis of and manner state	examination and/or in						
	To th Within To th	Me	29b. Signature and title of certifier	ma low)		29c. Licens			29d. Date signed	(Month, Da	ay, Year)
	V		30. Name and address of person with DR. CARL MARGOLI	s occumpleted cause of de	eath (Item 23a) (Type, CKVILLE PI	Print) #211,	ROCKV	ILLE, MARY	LAND 20	852	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 20 2	32 Registra	r's Signature	who a					

		•	1 - For State Registrar	State of Mar	yland / I		tment of I <i>ificate of</i>		and M		ene	6	03589
		ř,	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Nina Viola	a Singer	:					01-29-			8:45a [™]
1 2	Examin	£.,	4a. Facility Name (If not institution, give s	street and number)			4b. City, Town,	or Location o	of Death		4c. County	of Death	
6.5			3387 Water St	ceet			Manch	ester	:		Ca	rro]	1
	Funeral Director		5. Social Security Number 6. Sex 216-28-0402	7. Age	(In yrs. last bi	thday)_ Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, 1)	Year) 931	9. Birthpi Coun	lace (State or Foreign try) MD
	۳ پ		Usual Residence of Decedent		10c. City, Tow		ation o					10	Od. Inside City Limits
	anyla ehov	_	MD 10b. County Carrol				ster					"	1 Tes 2 No
	8a-f	Director			riai		10f. Zip Code			10	g. Citizen of W	/h C	
	with t		10e. Street and Number					100					uy:
	s 23	erai	3387 Water Sti	CEET 12. Was Decedent Ev	or in II S	12 W		102	gin? (Sne	cify Yes or No.	US 14 Bace	A - Americ	an Indian
36	d within 72 hours after death with the Maryland jiene. r then "neturel", or itema 23a or 28a-f ehow tra Madical Examinar mant be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes No If Yes, Give Year or Dates:			as Decedent of Yes, specify Cul		, Puerto F	Rican, etc.)		k, White,	
21215-0036	ture ture		15. Decedent's Edu		16a	. Decede	nt's Usual Occu	pation		1	6b. Kind of Bu	siness/Inc	dustry
15	in 72 n "net Negle	Completed	(Specify only highest grade	e completed)		(Give k	ind of work done O NOT use retire	durina most	t of workir	ng			•
212	d within giene. r then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	'	H	omemak	er			Own	Hon	ne
פַ	othe	0	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M	aiden Sumam	e)	
Maryland		To B	James Wear	/er				E	Bern	ice C	Cooper		
lan	2 shoul and Me is mark aumati		19a. Informant's Name/Relationship (Ty				•			Route Number,			
	s 1 and 2 should f Health and Mer frem 27 is marke other traumatic		James J Singer	- Husbar				St.,		chester			
ore			20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemete	ry, crema	tion (Name of atory or other pla				Oc. Location -	,	. –
Ë	ment ment inny		4 ☐ Donation 5 ☐ Other (Specify)		New		heran				ianche		
Baltimore,	permit Deper impor eny in	22 Name and Address of Familia I increase										Home MD 2	21074
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on any	he death. Do	not enter				r respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, 5 0	EAS	T	CA	NO	R				Once and Death
	/Medical		resulting in death)	Due to (or as a	consequence	of):							1
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	ed isi	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	or).							
	and J-tran	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence	of):	_					-	
8760,	cate be executed oblysicien and the burial-transit	a E				,							
387	B 문 #	dicai		J									
×	death certifi e ettending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of							23d. Date	e of delive	nry
Вох	leath etter	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti			ctopic pregnant Other (specify)	су			Mor		Day Year
o.	at the de by the teched	ysi	9 Unknown	9□ Unknown									
٠. ح	de ed	by PI	Part II. Other significant conditions con	ntributing to death but	not resulting	in the und	derlying cause g	iven in Part I.		23e. Did toba	acco use contr	ribute to th	e cause of death?
Vital Records,	w requires been sign should be									1 ☐ Yes	2 ⊡ No	3 Prob	ably 4 □Unknown
ပ္သ	s bee	Completed								24a. Was an autopsy	24b. V	Vere auto	psy findings available
æ	The lay	Eo			_					perform	ed?	leath?	2 No
ta		0	25. Was case referred to medical					26. Place	of Death	(Check only one			
<u>></u>	Physicien: this certific ral director,	To B	examiner? 1 Tyes 2 No	lospital: 1 Inpatient	t 2□ER/0	utpatient	3 DOA C	ther: 4 🗆 Nu	irsing Hor	ne 5 Resider	nce 6 Othe	er (<i>Specif</i> y	y)
٥٥			27. Manner of Death 1 ■Natural 5 ■ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Inj			8d. Describe how			
<u>ō</u>	andir. ath. or: Al	atic	2 Accident investigation			,		Yes 2	No				
Division	iel or Attendii s efter death, el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, f (Specify)	arm, stre	et, factory, office	•	2	28f. Location (Stre City or Town,		er or Rura	d Route Number,
	urs of rel D												
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: Alte completely filled in by the fune	Medical		ner: On the basis of a	examination a								
	To the To the Complet	Med	29b. Signatur, and title of certifier	and manner state	90.		29c. Licer	se number		29	d. Date signed	i (Month,	Day, Year)
	FFFO		MILLIA	Kunles	1	W	T	35	39	7	1/3	0/	06
h.	مالح		30. Name and address of person who co	ompleted cause of dea	ath (Item 222	(Type 9	Print)	00	110	<u></u>			-~
JY	5		Fhunholstar	22) 555	South	0	uter S	treet	100	tminsta	· MX	0157)
100	St.	ite	31. Date filed (Month, Day, Year)	32. Segistrar	's Signature		- 40 =				71100	., -,	
				Right A		-	and the state of t						

			1 - For State Registrar		Marylar	nd / Depa <i>Cei</i>	artmen rtificat					Reg. No:	006	03590
Н	Physici	an	Decedent's Name (First, Middle, Last)							Date of De Month	aath Day	Year	
	/Medic		Norma Gray Shaf							/0 //	Januar		, 2006	
	Examin	er	4a. Facility Name (If not institution, give		ber)				Location of	of Death			County of De	
	Euporal		852 Boatswain Wa 5. Social Security Number 6. Se		. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Bi (Month, D		nne Ar	irthplace (State or Foreign Country)
П	Funeral Director		288–12–6296	M 200€	83	Yrs.	Months	Days	Hours	Min.	(Month, D 2-19-	a <i>y, Year)</i> -1922	Oh	
	ը ,		Usual Residence of Decedent											
	show	2	10a. State 10b. County Maryland Anne Aru	ndel	10c. Ci	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-1	ect	10e, Street and Number			· · · · · · · · · · · · · · · · · · ·	10f. Zip	Code				10a Citia	en of What (**
	with of a	١	852 Boatswain Wa	v			101. 2.10	214	401			rog. Citiz	USA	20 unity ?
	within 72 hours after death with the Maryland ene. than "neturel", or Itema 23e or 28a-f show he Madical Exeminar must be netitied at	Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U	J.S. 13.	Was Deced			gin? (Spe	ecify Yes or N Rican, etc.)	0- 1	4. Race - An	nerican Indian,
စ	after or Ite	F	1 ☐ Never Married 2 Married	Armed Ford	X No		lfYes,speo 1 □ Yes :				Rican, etc.)		Black, Wh	
ğ	rel', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1 L Yes	21234NO	Specify:				Specify: W	Mite
5-	netu dea	Completed	15. Decedent's Edi (Specify only highest grad	cation e com <i>pleted)</i>		16a. Dece (Give	kind of wo	k done d	uring mos	t of worki	ng	16b. Kir	d of Busines	s/Industry
12	within ane. than	dmo	Elementary/Secondary (0-12)	College (1-		me.	DO NOT us		,				TI-21.0	. L. J. o. o.
0 0	filed Hygi Sthar	ပိ	17. Father's Name (First, Middle, Last)	4 years			Teac	er	18. Mothe	er's Name	(First, Middle	, Maiden	Educa Sumame)	(CTOI)
au	ld be lental ked c	To Be	Norman Gr	av						E	thel L	eMast	ers	
Maryland 21215-0036	shou and N and N		19a. Informant's Name/Relationship (T	rpe, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	il Route Numl	er, City or	Town, State	, Zip Code)
Σ	and 2 saith n 27 i		H. Clinton Shaffe	r/Husba						Ann	apolis	, MD	21401	
ore	of Heror		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from S	tate 20b. I	Place of Dispo cemetery, crei	sition (Nan matory or o	ne of ther place			Date	20c. Location - City or Town, State		
Ē	E Pag tment tant:		4 □Donation 号□Other (Specify			las Cr				1-21			ewater	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Itema 23e or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at ance.		21. Signatur of Funeral Service Licens	00		20	2. Name an	d Addres	s of Facilit	y Geo	orge P.	Kala 'daawa	as Fund	eral Home Maryland 2103
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. SC Due to (c	HEMICO as a consecutive of a consecutiv	quence of): Quence of):	77E[· C	troi Disc	OMY A SE	OPATI	ty	DUCEAS	Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	ical	resulting in death) Last	c. PROGNESSIVE ARTERIEL OBSTRU Due to (or as a consequence of): d. HYPERLIPIDEMIT										
P.O. Box 68	Attending Physicien: The law requires that the death certifica r death. cload. ector: After this certificate has been signed by the attending phe principle in the functal director. Page 2 should be detached for use as it.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 TNo 9 □ Unknown		nth 2 ☐ Feta ant at time of o	al déath 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of d Month	elivery Day Year
s, P	res that igned b be deta	y P	Part II. Other significant conditions co	ntributing to de	ath but not re	sulting in the u	nderlying c	ause give	n in Part I	•	23e. Did	tobacco u	se contribute	to the cause of death?
rds	w require been sig should b	ed	CHRONIC OBSTRE	CTIVE	LUNG	DISE	155	HK	31+		10	Yes 2]No 3□	Probably 4 □Unknown
Vital Record	i: The law requicate has been cate has been cate has been categories.	Completed	CHRONIC OBSTRU BLOOD PRESSUR	E, A	soone	NALI	HORT	CA	NEU	eyfn	pen	s an opsy ormed? 200 No	prior to death	autopsy findings available o completion of cause of ? es 2 No
ξ	sicier certif recto) Be	25. Was case referred to medical examiner?	Hospital:		7500		Othe)C		(Check only			
ŏ	nding Physicien: The lavath. ath. rr; After this certificate has te funeral director, page 2	ation: To	1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time o Injury		8c. Injury Work	at at		me 5 🙀 Res 28d. Describe			necity)
Division	To the Hospital or Attendity within 24 hours after death. To the Funeral Director; A completely filled in by the funeral and t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	buildin	g, etc. (Speci						City or To	wn, State)		Rural Route Number,
	Host 24 ho Fune stely fi	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	iner: On the ba	best of my kn sis of examina er stated	owledge, deat ation and/or in	n occurred ivestigation	at the tim in my op	e, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) , date and	and manner place, and d	as stated. ue to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier 30. Name and address of person who of ANDREW Go ROOM 31. Date filed (Month, Pay, Year) 200	M			290	License	number	7		29d. Date	signed (Mo	nth, Day, Year)
			30. Name and address of person who o	ompleted cause	of death (Ite	m 23a) (Type,	Print)	Ste 1	(00) +	An/N	AASLIC	me) 21	401
	Sta Regist	ite rar	31. Date filed (Month, Day, Year) 200	32. Re	gistrar's Sign	ature	and a	/		,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			

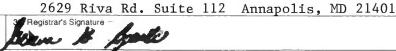
Division of Vital Records, P.O. Box 68760

State Registrar

31. Date liled (Month, Day, Year) JAN 2 4 2006

Sharon Messics

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		1	For State Registrar	State of		d / Depa	artment of H	lealth and		/giene Reg. No.	06	03592
			Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia		WILLIE SADLER J	R.					JANUAR			7:03A M
ı	/Medic Examin		4a. Fecility Name (If not institution,		ber)		4b. City, Town, or	Location of Dear	th	4c. (County of Death	
ı	LAGITIII		PRINCE GEORGE HO	SPITAL			CHEVERLY	Z		PRI	INCE GEO	ORGE
	Funeral			6. Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth (ay, Year)	9. Birth Cou	place (State or Foreig
	Director		578-58-3966	1 X M 2 □ F	58	Yrs.	World S Days	110010	01-09-			I CAROLINA
	D.		Usuel Residence of Decedent		40- 01-	, Town or Lo						10d, tnside City Limits
	show		10a. State 10b. County MD PRINCE	CEORCE	'	HILL						1∭ Yes 2 □ No
	3a-1 s	cto		GEURGE	OAO	A IIIII				10- 01-		
	or 28	Director	10e. Street and Number				10f. Zip Code				en of What Cou	intry r
	23a	ai	1100 OWENS RD #5				20745			U.S.	A . 4. Race - Amer	iona Indian
	ems ems	Funerai	11. Marital Status	12. Was Deced	ces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue	Specify Yes or Note Rican, etc.)	10-	Black, White	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Medical Exartirar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 3 If Yes, Give Year or Da	ZX No		1 ☐ Yes 2¶ No	Specify:			Specify: BLA	ACK
Maryland 21215-0036	tural tural	pe p	15. Decedent		103.	16a, Dece	dent's Usual Occup	ation		16b. Kin	nd of Business/II	ndustry
7	in 72 "na ledic	Completed	(Specify only highest	grade completed)	45-1	(Give life.	kind of work done DO NOT use retired	during most of wo d)	orking			
7	with ene. thar	E	Elementary/Secondary (0-12) 11th	Cotlege (1-	40r 5+)	МЕСНА	NICAL ENG	GINEER		GOVI	ERNMENT	
0	filed Hygi sther		17. Father's Name (First, Middle, L	ast)		.120111			me (First, Midd	le, Maiden .	Sumame)	
an	d be ental ked c	To Be	WILLIE LEE SADLE	ER				GERALD	INE LAT	TIMORI	Ξ	
2	should ind Men s marke umatic	-	19a. Informant's Name/Relationsh				ng Address (Street					
Š	and 2 salth at n 27 is		CHANTE M. SADLE	R/DAUGHTEF	₹	3018	BRIGHTSE	AT RD #	304 LAN	HAM, N	MD 20706	5
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition			lace of Dispo	osition (Name of matory or other place	ce)	Date	20c. Loc	cation · City or 1	Town, State
	Pages nent of ant: If it ury or o		1 🕅 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		state	-	ION CEM.		21-2006	CLIN	TON, MD	
Ė	artme ortan injur	1	21. Signature of Funeral Service L		11		2. Name and Addre					OME
Ba	permit. Departr Importa any inj		DX N.N.	-hall			474 LANDO					
			23a. Part1. Enter the disease, or	complications that ca	used the deat							Approximate Interval Between
			shock, or heart failure. List of Immediate Cause (Final			DCEIDO	MONAC					Onset and Death 7 DAYS
	Physician /Medical		disease or condition resulting in death)	a	IONIA- : or as a conseq		MUNAS					7 111110
	Examiner						RY FAILUI	RF.				6 MONTHS
	1000	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury		or as a conseq		KI IMIBOI					
	ite be executed sysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury									
	be executed Ician and burial-transit	Xai	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
760,	te be e yslciar ie buri	cai		d								
89	leath certificate t attending physl											
Вох	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		□Ectopic pregnanc	· · ·		2	23d. Date of deli	
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	ant at time of d		Other (specify)	,		-	Month	Day Year
0	t the de by the tached	hys	9 Unknown	9 Unkno	own							
0	s that ned b	by P	Part ti. Other significant condition		eath but not res	ulting in the	underlying cause gr	ven in Part I.				the cause of death?
Records,	quires n sign uld be	<u>8</u>	DIABETES MELLI	rus					- 1(Yes 2	_No 3 □ Pr	obably 4X Unknow
00	w requ	Completed	CHRONIC RENAL	FAILURE					24a. W	as an topsy	24b. Were au	itopsy findings availab completion of cause of
Re	о <u>г</u> ж	ШС				-			pe	rformed?	death? 1 ☐ Yes	
Vital	iclan: Th certificate ector, pag	O	25. Was case referred to medical					26. Place of D	eath Check on			
5	Physiclan: this certific	0 0	examiner? 1 Yes 2 XNo	Hospital:	npatient 2X	ER/Outpatie	ent 3 DOA	her: 4 Nursing	Home 5 Re	esidence	6 ☐Other (Spe	cify)
o			27. Manner of Death	28a. Date	of Injury	28b. Time Injury	of 28c. Inju		28d. Describ			
on	ding th: Afte	i i	Natural 5 ☐ Pendin 2 ☐ Accident investig	g	ii, Day 1 dai)	mary		Yes 2 No				
Division	or Attending after death. Director: After	ifice	3 ☐ Suicide 6 ☐ Could i	inod 288. Place	of Injury - At h	ome, farm, s	treet, tactory, office			(Street an Town, State		ural Route Number,
á	al or A safter Il Dire	Certification:	4 Homicide	Duildi	g, s.c. (apaci	.7/			, 5/			
	To the Hospital or Attenwithin 24 hours after death to the Funeral Director: completely filled in by the		29a. Certifier Certifyin	g Physician: To the Examiner: On the b	best of my kn	owledge, dea	th occurred at the t	ime, date and pla	ice, and due to t	he cause(s)	and manner as	s stated.
	the Ho hin 24 h the Fu npletely	Medical	(Check only 2 Medical one)	and man	asis of examining	ation and/or	rivestigation, in my	ориноп, ават ос	oungulat the th			
	To the within To the comple	Z	29b. Signature and title of certifie	1////	ald		29c. Licen	se number	RAM	29d. Da	te signed (Mont	я, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REVATHY MURTHY M.D. 6130 LANDOVER ROAD CHEVERLY, MARYLAND 20785

State Registrar 31. Date filed (Month, Day, Year) JAN 2 4 2006



State of Maryland / Department of Health and Mental Hygiene 📗 🗎 03593 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JAN. Physician 21, 2006 BLANCHE G. SEYMOUR 8:30 A M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES Gentle Steps Assisted Living Riverdale If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 19,1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M **X**□ F Months Days Hours 68 055-32-8038 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County "natural", or items 23s or 28s-f show ofcal Examiner out the notified at 1X Yes 2 □ No Director Albany Albany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
snt: if item 27 is marked other than "natural", or items 23s or 2 ury or other traumatic event, the Modical Examiner must be in 12205 U.S.A. 85 Hunting Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes X☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montg. Co. College (1-4or 5+) Elementary/Secondary (0-12) Psychiatrist Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy D. Tensley Russell D. Seymour 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Health ar important; if item 27 ie sny injury or other trau 85 Hunting Road, Albany, NY Don I. Seymour (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 21 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Serv 1/25/06 Alexandria, VA Metro 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatura Funeral Service Lice 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death RESTRATORY FAILURE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTROINTESTINAL HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed NEUROLOGICAL Due to (or as a consequence of) attending physicien a for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown GASTRUSTU MY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hes b 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this After this funeral d 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending efter death. I Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours e To the Funerel C filled Certifying Physician: To the base of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06 17311 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 57 N.W. NORTH TOWER # 4200

FRANCISCS KIND, MD WASHINGTON, DC 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 5 2006 Registrar

Linda E. Spence Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Unpend item#1, 23, Pl1, 27, pen E, 3852, 2/10/00 11

Amend item#1, pen E, 6853, 3/2/00 Tourificate of Death 06-00502 1 - For Stete Registrer 03594 CT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Linda Spencer January Linda E. Spence 2006 3:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2517 Iverson Street Temple Hills Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 28, 1947 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√□ F 58 Washington DC 577-64-1668 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location il Hygiene. other than "neturel" or leame 23a or 28e-f ehow vent, the Medical Espiriner must be notified at 10a, State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 □ No MD Prince George's Temple Hills Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WIT 2517 Iverson St 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Black ģ 3 ☐ Widowed 4 🏗 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Assistant Government permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other eny lighty or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Mease Elizabeth Clark ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry O Mease 7301 Quetzal Dr Bowie MD 20720 Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2/2/06 4 □ Donation 5 □ Other (Specify) Alexandria Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 101085 23a. Part1. En Ir the dis Se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Securitizity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit ettending physicien and Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of de □h?

1 ⊻ Yes 2 □ No certificete 1 Yes 2 No completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Y∑Yes 2 No ۵ Pis 27. Mapper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospitel or Attending 1 Natural Injury 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mie OCME January 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING MID 1 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar FFB 0 1 2006

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a, State

Director

Completed by Funeral

Be

Funeral

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e tiled within 72 hours after death with the Maryland at Hygiene.
I other than "natural", or freme 23s or 28s-f ehow vent, the Medical Examinet must be notified at

permit. Pages 1 and 2 should be tiled v Department of Health and Mental Hygies Important: If Item 27 is marked other it any injury or other traumatic event, ILM 2005.

Baltimore, Maryland 21215-0036

use as the burial-transit and the attending physician

Physician/Medical

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Completed

Certification:

The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director.

SC.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EBROVAS CULAR 25 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

ERRY 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Mac

STREET. MOUNTRAINIER 32. Registrar's Signature

JAN 2 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMA

State

Registrar

D19609

29d. Date signed (Month, Day, Year)

2.06

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Jan. 23, 2006 Physician H. Gerard F. Siems II 7:10p M /Medical 4c. County of Death Montgomery Co. 4b. City, Town, or Location of Death ROCKVILLE 4a. Facility Name (If not institution, give street and number)
National Lutheran Home Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Aug. 14, 1918 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 218-03-5288 1 XM 2 ☐ F 87 Yrs Director Usual Residence of Decedent 10c. City, Town or Location
Silver Spring 10d. Inside City Limits the Maryland 10b. County 28a-f show traumatic avant, the Medical Examiner must be notified at Md. Montgomery 1X Yes 2 ☐ No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 20910 USA 9512 - Hale Street Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11. Marital Status Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ Year or Dates: 1943-45 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nat.Security Agency Cryptanalyst 3 Yrs 18. Mother's Name (First, Middle, Maiden Sumame)
Faith J. Linker 17. Father's Name (First, Middle, Last) Be (John Louis Siems 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9512- Hale Street, Silver Spring, Md. 20910 19a. Informant's Name/Relationship (Type, Print) Jonathan Siems- Son othar 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Wash.Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/27/2006 Adelphi, Maryland injury or tant: 4 ☐ Donation 5 ☐ Other (Specify) Departi Import any inj once. 21. Signature of Funeral Sen d Licensee 22. Name and Address of Facility m Hysong Co., In c. 6510- 16th Street, N.W., Wash. DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DYSRRHYTHAS CARDIAL /Medical Due to (or as a consequence of): **Examiner** ALZHIEDERS DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit MIRIOL FRZILLA 10N Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death Year Month Day ŏ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 🗀 Yes 2 No death. 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 124 hours a Tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20051158 JANUARY 24 2006 VINEYUL BU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE Mp 20850 9701 DRIVE · AW THO MY VEIGLS VATTLIT 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 6 2006 Registrar

		1	State of Maryland / Department	artment of Health and M Tificate of Death		one 006 03597
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physicia		Sammy	Shen		18, 2006 12:30P. M
	/Medic Examin	aı -	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LXdiiiii	Ų.	Washington Adventist Hospital	Takoma Park		Montgomery
	Funeral Director		5. Social Security Number 6. Sex $1 \square XM$ $2 \square F$ 7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth April 19	9. Birthplace (State or Foreign Quantry) China
	D	_ H	Usual Residence of Decedent 10a State 10b County 10c City, Town or Le	cation		10d. Inside City Limits
	show	-	10a. State 10b. County 10c. City, Town or Lo Maryland Prince George's Beltsvil			1 ☐ Yes 2X No
	7-68 7-68	ecto	, , , , , , , , , , , , , , , , , , , ,	10f. Zip Code	100	g. Citizen of What Country?
	with t	۵	10e. Street and Number 11222 Cherry Hill Road, #201	20705		United States
	s 23	eral	· ·	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Items 23e or 28e-f show empretent: if Item 27 is marked other then "netural", or Items 23e or 28e-f show empretent injury of the Train	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 📉 No Specify:	Rican, etc.)	Black, White, etc. Specify: Chinese
Baltimore, Maryland 21215-0036	2 hou	per		dent's Usual Occupation kind of work done during most of work		6b. Kind of Business/Industry
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פ	e file othe vent,	BeC	17. Father's Name (First, Middle, Last)	,	ne (First, Middle, Ma	
<u>a</u>	Ald by Alenta Alenta rked	To E	(unk) Shen	(unk)		Chou
ary	short and h		1,7,7	ng Address (Street and Number or Ru		
2	and 2 alth a 27 I					eltsville, Md. 20705
J.	T P P P			matory or other place)		0c. Location - City or Town, State
E	Tri F		'4 Donation 5 Other (Specify) Gate of	Heaven Cemetery 1	/23/2005	Silver Spring, Marylan
att	mit. partm porte y inju		21. Signature of Funeral Service Licensee	Name and Address of Facility and	t Funeral	Home, PA
m	99 = 9		Horald V. organist	400 Powder Mill R	oad Belts	ville, Maryland 20705
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
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	/Medical		resulting in death) a. Due to (or as a conservence of):	0	cuy	/
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Record	w requir been s should	Completed	Aut rent factor, trypistaline	1 1750 (6. 400)	242 1452 25	24b. Were autopsy findings available
ec	e law has b	nple	Atrial of shriften paciticles.	10 Defibrilletu	24a. Was ar autopsy perform	prior to completion of cause of death?
E 30	Thate ate	Con	Sarcotristoid Carcinome	right thest		No 1 ☐ Yes 2 ☐ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	ath (Check only one	
of\	ys dis	2	1 ☐ Yes 2 X No Hospital: 1 Impatient 2 ☐ ER/Outpatie	ent 3 DOA 4 Nuising P	lome 5 Reside	nce 6 Other (Specify)
	ing P	on:	27. Manner of Ueath 1 Natural 5 ☐ Pending 28a. D te of Injury 1 Natural 5 ☐ Pending 28b. Time 1 Injury 1 Injury 1 Natural 1	Work?	200. Describe no	w many occurred
Sio	eath. or: A	catl	Accident investigation 3 Suicide 6 Could not be 388 Place of Injury - At home farm		28f Location (Str	reet and Number or Rural Route Number,
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town	, State)
	urs al		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th accuract at the time, data and place	and due to the ca	uise(s) and manner as stated.
	Hosp 4 hou Fune fely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occi	urred at the time, da	ate and place, and due to the cause(s)
	the the	Med	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
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			30. Name and address of person who completed cause of death (Irem 23a) (Typ	6/ (lun Con	10 D 20901
			31. Date field (Month, Day, Year) 32/Pegistrar's Signature	Jus. 1)v.)11	res son	7 11
	St Regist	ate trar	JAN 2 4 2006 / 100 15 14	18AGA)	1	\$/
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				ate of Maryland	/ Depa		lealth and l	Mental Hyg	iene	e. 5
ı	Physici /Medio	al	Negistrar Decedent's Name (First, Middle, Last) ELIZABETH MARIE SHE 4a. Facility Name (If not institution, give street)				r Location of Deat	2. Date of Dea Month JANUARY		
	Funeral Director	eı	NATIONAL INSTITUTES 5. Social Security Number 215-36-2946 6. Sex	OF HEALTH 7. Age (In yrs. Ia.	st birthday) Yrs.	BETHESI If Under 1 Year Months Days		8. Date of Birth	MONTGO	
Ī	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the s 23s or 28 rust be no	ral Director	10e. Street and Number 7101 Roslyn Avenue			10f. Zip Code 2085			United S	tates
900	72 hours after death with the Maryland Insture!', or Items 23a or 28e-f show dical Examiner must be notified at	by Funeral	A 1 Never Married 2 Married 1	/as Decedent Ever in U.S rmed Forces? □Yes 2 Tho Yes, Give ear or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☆ No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Hace - Black, Specify:	American Indian, White, etc. White
21215-0	within ene. then "	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) — C	ollege (1-4or 5+)	(Give life. Incen	dent's Usual Occup kind of work done DO NOT use retire tive Awa rdinator	during most of word)	rking	16b. Kind of Busin Food and Administ	Drug
Maryland 21215-0036	should be filed and Mental Hygin marked other matic event, II	o	17. Father's Name (First, Middle, Last) Frank Joseph Cifala 19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailir	ng Address (Street	Nola Eli	ne (First, Middle, . Lzabeth S ural Route Numbe	Stone	ate. Zip Code)
	ermit. Pages 1 and 2 should be lepartment of Health and Mental mportant: If item 27 Is marked ny injury october traumatic evines.		Thomas E. Cook/ Son 20a. Method of Disposition 1 Regular 2 Cremation 3 Remove	20b. Pla	P.O.	•	Enosburg	g Falls,		05450
Baltimore,	permit. Pag Department Important: any injury once.		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensae	M00689	Ceme	tery . Name and Addre	ss of Facility De	06 E eVol Fune	ral Home	yermont urg, MD 2087
	Physician		23a. Paint. Enter the disease, or complication shock, or heart failure. List only one call immediate cause (Final disease or condition resulting in death)		Do not ent		ng, such as cardia			Approximate Interval Between Onset and Death
	/Medical Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque Due to (or as a conseque	ince of):	HOCK	11 -	_		2 Mys
3760,	ate be executed hysician and he burial-transit	lcal Examine	cause (bisease or injury that initiated events resulting in death) Last	Due to (or as a conseque Non-Hol	ence of):	OLAR 'S LY/	HEMON UPHOMA			YEARS
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	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contribu	ting to death but not result	ting in the u	nderlying cause giv	ven in Part I.			ute to the cause of death? Probably 4 □Unknown
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Division of Vital Records,	ding Phys n. After this funeral dii	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 inpatient 2 E	R/Outpatier 28b. Time o Injury	Wo	ner: 4 🗌 Nursing H	ath (Check only or Home 5 Resid 28d. Describe h		
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	To the Hospitel within 24 hours at To the Funerel Completely filled it	Medical	(Check only 2 Medicel Examiner: (To the best of my know On the basis of examination and manner stated. 	ledge, deat on and/or in	occurred at the ti vestigation, in my o	opinion, death occu	urred at the time, o	ause(s) and mann late and place, and 29d. Date signed (due to the cause(s)
	10		30. Name and oddress of person who comple					$(c\tau)$	Janua	1 1
	Sta Registi		JACQUELINE JANKA 31. Date filed (Month, Day, Year) JAN 2 4 2006	32. Registrar's Signatu	ro	TER DRIV	E, BETHES	SDA, MARY	LAND 208	92

			1 - For State Registrar	State of Marylan		artment of F			giene 06	03599
1	Physici		1. Decedent's Name (First, Middle, Las	3 u therlan	9			2. Date of Dea Month		3. Time of Death
***	/Medic Examin		4a. Facility Name (If not institution, give	street and number) Maryland Hospi	tal		Itimore	-		one
* 21	Funeral Director		5. Social Security Number 6. Se none	7. Age (In yrs.	-	If Under 1 Year Months Days		Hrs. 8. Date of Birt (Month, Da May20,	1. Year) 1. 959 Re	Birthplace (State or Foreign Country) P.ofTrinidad
	yland how		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	the Ma 28s-1 e	Director	Maryland Montgome	ery	Silve	r Spring			10g. Citizen of Wha	1 ☐ Yes 2X No
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980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Mudical Examiner must be muilified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Half Yes, specify Cub		? (Specify Yes or No uerto Rican, etc.)		American Indian, White, etc. Frican Americar
Maryland 21215-0036	within 72 ho ene. than "natur re M. disall	Completed	15. Decedent's Ed (Specify only highest granus)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Busin	ess/Industry
d 21	filed wil Hygien other th	е Соп	17. Father's Name (First, Middle, Last)		Mach	ine Opera		Name (First, Middle,	bottling Maiden Sumame)	company
ylan	2 should be and Mental le marked of eumatic eve	To B	Emmanue1	Campbe			Veron			Hayde
	and 2 sh lealth and m 27 le m		19a. Informant's Name/Relationship (7) Wilfred O. Suther:	• •				r Rural Route Numbe nor Drive	-	oring, Md. 20904
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If Item: any injury or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	ce) 1/	Date 31/2006	20c. Location - Cit Sangre Gr	y or Town, State rande, Trinidad			
Balt	Dermit. Depart Import any inj once.		21. Signature of Funeral Service Licen	agradt	ess of Facility Borgwa er Mill	rdt Funera Road Beli	al Home, l sville. 1	PA Maryland20705		
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_	eatic quence of):	canc		diac or respiratory a	rrest,	Approximate Interval Between Onset and Death I Month
68760,	death certificate be executed e attending physicien and of for use as the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq.	quence of):					
.O. Box	it the death certific by the attending p tached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of constitution of the co	al death 3	⊒Ectopic pregnand ∃ Other (specify) _	y		23d. Date o Month	,
rds, P.	quires that n signed b uld be deta	ξ	Part II. Other significant conditions o	ontributing to death but not res	sulting in the u	inderlying cause gr	ven in Part I.	- 1		rte to the cause of death? Probably 4 20nknown
of Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed			24a. Was autoj perfo 1 🗆 Yes	rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No			
Vita	Physician: This certificated director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hcspital: 1X Inpatient 2□] ER/Outpatie	nt 3 DOA Ot	hor	Death Check only on the Death Resi		(Specify)
ion of	ling After fune		27. Manner of Death 1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju			how injury occurred	
Division	P Ste	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (City or To		or Rural Route Number,
	Hospitel 24 hours Funerel etely filled	edical	(Check only one)	ysician: To the bast of my knoniner: On the basis of examinating and manner stated.	owledge, deal ation and/or in	h schimed at the to exestigation, in my	inie, date and p opinion, death o	lace, and due to the occurred at the time,	cauce(c) and many date and place, and	of its titaled. I due to the cause(s)
	within 2 To the I complet	Me	29b. Signature and title of certifier				se number		29d. Date signed (i	
,	4		MB LUSTher		m 23a) (Type,		090	ol MB	1/23/200	<i>b</i>
			27 South Gr	een St Bo	altimo	re MD	212	01 MB	Lustberg), MD.
A STATE OF	Sta Regist		JAN 24 2	32/Registrar's Sign	13. As	and it				

		1	For State Registrar	State of Maryla	•	artment of H			iene g. No. 006	03600
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Yea	3. Time of Death
	Physicia /Medic		Janet Barbara Sta	ley				January	7 23 2006	8:15 A ^M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	th	4c. County of De	
			Holly Place 268 S 5. Social Security Number 6. Sex		rs. last birthday)	Hage If Under 1 Year	erstown	8. Date of Birth	Washin	igton State or Foreign
	Funeral Director			M 20XF	96 Yrs.	Months Days	Hours Min		Year)	Country) (aryland
	ס		Usual Residence of Decedent							
	arylan show	_	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	Ba-1	1 × 1	Maryland Washingt	on	Hage	erstown 10f, Zip Code		1	0g. Citizen of What	
	with t		10e. Street and Number 268 South Potoma	c St.		· ·	1740		U.S.A	•
	na 23	Funeral		12 Was Decedent Ever in	n U.S. 13.	Was Decedent of Hill If Yes, specify Cuba	ispanic Origin? (Specify Yes or No-		nerican Indian,
9	s within 72 hours after death with the Maryland Jiene. I than Instural', or Itema 23e or 28e-1 show The Maulical Examiliar must be maillied a	Fun	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give		It Yes, specity Cuba 1 □ Yes 🄀 □ No	n, Mexican, Pue Specify:	no Hican, etc.)	Black, W	White
21215-0036	ural', c	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						
5-("natu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Docupa kind of work done of DO NOT use retired	during most of wi	orking	16b. Kind of Busine	ss/Industry
12	filed within Hygiene. Sther than "	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		Jursing As	•		Hospit	al
9	Hys Hys	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sumame)	
<u>lan</u>	V to O	To B	Joseph Faulder				Lorre	ta Corine	e Brewer	
Maryland	sh and sum	. 5	19a. Informant's Name/Relationship (Ty						r, City or Town, State	
	1 and 2 Health tem 27			laughter)	b. Place of Dispo		nberry F	o. nagers	20c. Location - City	rland 21740
Baltimore,			20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre-	matory or other place en Cemete:	ry 1-2	26-06		own Maryland
Balt	permit. Page Department Important: If any injury or		21. Signature of Funeral Service License	Paulan		2. Name and Address 331 Easte:	ss of Facility [rn Blvd.	ouglas A. N. Hagen	. Fiery Furstown Mar	neral Home Tyland 21742
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the d	eath. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
E	Physician	9 V	Immediate Cause (Final disease or condition	Sivile	denes	hA.				year 5
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	LXummer	<u></u>	Sequentially list conditions,	Due to (or as a cons	sequence of):					
	ted nsit	뒤	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or mury							
Ć,	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be hysicia the bur	dlcal		1.						
9	ng ph	Med	IF FEMALE:							
Вох	leath certifica attending pharmand for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3[Ectopic pregnancy	,		23d. Date of	delivery
	the a	ysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	or death 51	Dther (specify) _				
P.0	The law requires that the death centificate be executed the sas been signed by the attending physician and tage 2 should be detached to use as the burial-transit		Part II. Other significant conditions con	ntributing to death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	uires n sign lid be	d by	Phermatoid	forther tis	>			1 □ Y	es 250 No 3□	Probably 4 Unknown
Records,	s been s should	Completed						24a. Was a		autopsy findings available to completion of cause of
Re	siclan: The law certificate has b lirector, page 2 s	mo						autop perfor		1?
ita	10	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or	18)	
of Vital	Physiclan: this certific ral director,	70	1 ☐ Yes 2 No		2 ER/Dutpatie		4 be Nursing	-	ence 6 Dther (S	pecify)
n o		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer	r) 28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe h	ow injury occurred	
Sio	Attanding or death.	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm st		162 5 140	28f. Location (S	itreet and Number or	Rural Route Number,
Division	after after Direction by	Certification;	4 ☐ Homicide determined	building, etc. (Sp	ecify)	radicity, dinoc		City or Tow	m, State)	
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	edical C		sician: To the best of my ner: On the basis of exam and manner stated.						
	To the within To the comple	Me	29b. Signature and title or certifier			29c. Licens	number 7949		29d. Date signed (M	onth, Day, Year) 5, 2006
			30. Name and address of person who	ompleted cause of death ((Item 23a) (Type	. Print)	-1111			
05	H-3		Steven Hatle	era 11110 A	Medical	Campus	Rd He	19c/stow	n, MD	21742
		ate	31. Date filed (Month) Day, Year)	32. Registrar's Si		1				
	Regist	rar	2011	006 Janear	A. P.	perde				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrer	State of Maryla		artment of H			giene 006	03601
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Claude Edgar Stark					2. Date of Dea	Day Ye	ar 3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s Memory 10 5. Social Security Number 218–16–3934	Oital 7. Age (In yr	s. last birthday) 30 Yrs.	4b. City, Town, of the Under 1 Year Months Days	Orla If Under 24 H	eath ind	4c. County of E	Peath AND A Birthplace (State or Foreign Country) nnsylvania
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Garrett		City, Town or Lo					10d. Inside City Limits 1 1 Yes 2 □ No
	with the I a or 28a-	Funeral Director	10e. Street and Number 119 Miller Street	OL C	AIICS VIII.	10f. Zip Code 21536			10g. Citizen of What	Country?
036	be filed within 72 hours after death with the Maryland all Hygiene. Id other then "natural", or items 23e or 28e-f show other then "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WW2		Was Decedent of Hilf Yes, specify Cub.	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- perto Rican, etc.)	14. Race - A	imerican Indian, Phite, etc.
21215-0036	d within 72 ho giene. or then "natur ir e Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Labor	dent's Usual Occup kind of work done DO NOT use retired	pation during most of d)	working	Fire Bri Manufact	ess/Industry Ck
ਲੂ	ould be filed v Mental Hygie arked other i atic event, IL	Be	17. Father's Name (First, Middle, Last) Clyde Stark					Name (First, Middle, Bowser	Maiden Sumame)	
, Mar	and 2 sho eelth and n 27 is m		19a. Informant's Name/Relationship (Typ. Susan D. Brenneman/	Personal Rep	P.O.	Box 35,			r, City or Town, Stat 21536	e, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be Dapartment of Health and Mania Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 35 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei ttinger	esition (Name of matory or other place Cemeters	Jan	Date 20,2006		r, MD
Ball	permit Dapar Impor any in		21. Signature of Fhyral Service License 23a. Part1. Enter the disease, or complic	mai	P.	O. Box 2	75, Gra	ewman Fun ntsville,	MD 2153	
	death certificate be executed Ram Medical Med	dical Examiner	shock, or heart fallure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. Acute (e) Due to (or as a conse	equence of):	asculai				Interval Between Onset and Death 4 Clay 5
	death certi e attanding d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
<u>a</u>	89 PG	Ď	Part II. Dther significant conditions conf	tributing to death but not re	esulting in the u	ndertying cause giv	en in Part I.			e to the cause of death?
l Rec	aw is t	Completed						24a. Was autop perfor 1 Yes	sy prior med? death	autopsy findings available to completion of cause of 1? Yes 2 M No
Zi Zi	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	□ EB/Outpatier	it 3□ DOA Oth	on	Death <i>(Check only or</i> g Home 5 ☐ Resid		Specify)
ion of	ding P. After fune		27. Manner of Death 1 ™ Natural 5 Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			ow injury occurred	pocity
Divis	Itel or Atten Its after deat rel Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel o within 24 hours af To the Funeral Di completely filled in	edical	29a. Certifier 1	ician: To the best of my keer: On the basis of examinand manner stated.	nowledge, deatl nation and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the o ccurred at the time, o	cause(s) and manner date and place, and	r as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	'hotani.		29c. Licens	e number 8853	2	January	onth, Day, Year) 20, 2006
			30. Name and address of person who con	mpleted cause of death (It	em 23a) (Type,	Print)	VPNIIP	Cumberl	and Mis	20, 2006 21502
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 201	32. Registrar's Sig	nature		M		the second of the second	J. S.

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January 25 **Physician** Virginia Stottlemver 2006 6:30 Mildred /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAY | 191 | 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 217-34-0346 93 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director MONTGOMERY DICKERSON 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 22022 BIG WOODS ROAD 20842 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within to f Health end Mental Hygiene. If item 27 ie marked other then or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MABLE HUNGERFORD WALTER POOLE 2 9b. Mailing Address (Street and Number of Hural Houte Number, City of Transport MD 19205 BEALLSVILLE RD., BEALLSVILLE, MD 20839 19a. Informant's Name/Relationship (Type, Print) 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health e, Important: if item 27 ie any injury or other trat once. LINDA BODMER / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MONOCACY CEMETERY 1/28/06 BEALLSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 20838 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** 24 hes Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons --- ence of) Examiner -transit thet the death certificate be executed and physicien ar Due to (or as a consequence of): Box 68760, ician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö Physi 9 Unknown signed by t م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ The law requires 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has this certificate 1 ☐ Yes 2 ☐ No 1□ Yes Vital 2 No : After this certification funeral director. 25. Was case referred to me -1 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ot 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1 ANatural 5 Pending Injury efter death. Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗍 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide within 24 hours efter To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, Md 21701 mo Be ker CARELS. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Breeze It Agent 2006 Registrar

ORIGINAL

		For State Registrar	State	of Maryla		artment o rtificate d	f Health a of Death		, ,	iene	06	0360	03
Di di di		1. Decedent's Name (First, Middle,	Last)					2	Date of Deat	h Day	Year	3. Time of D	eath
Physicia /Medic		Drew S. Si	lege1					J	January		2006	7:39	\mathbf{p}_{M}
Examin		4a. Facility Name (If not institution,	•			4b. City, Tow	m, or Location o	of Death		4c. Count	y of Death		
		Montgomery Gene: 5. Social Security Number	ral Hosp: ^{6. Sex}		s. last birthday)	Olne		24 Hrs. 8	. Date of Birth	Montg		place (State or I	Famina
Funeral Director		219-96-5430	1 X M 2 □ F	39			ys Hours	Min.	(Month, Day,	Year)	Cou	ington,	
D		Usual Residence of Decedent				1				, 1,00			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23a or 28a-f show important: If item 27 is marked other then "netural", or iteme 23a or 28a-f show eny Injury or other treumatic event, the Medical Examination metal be notified at once.	_	10a. State 10b. County			City, Town or Lo							10d. Inside City 1 XYes 2	
188-f	Director	Maryland Montgo	mery	ROC	ckville								:
with t	吉	10e. Street and Number				10f. Zip Coo			1	0g. Citizen of		ntry?	
eath must	Funeral	12716 Parkland I		cedent Ever in	US 13		of Hispanic Orio	igin? (Specif	fy Yes or No-	U. S.		can Indian,	
r Item	E I	1 Never Married 2 Marrie	Armed F ad 1 ☐ Yes	orces?	0.0.	If Yes, specify (of Hispanic Orig Cuban, Mexican	, Puerto Rio	can, etc.)	Bla	ck, White,	etc.	
al', o	þ	3 Widowed 4 Divorced	If Yes, G Year or I	ive		1□Yes 2□X	No Specify:			Speci	ty: Whi	te	
72 ho	Completed	15. Decedent' (Specify only highest)	16a. Dece	dent's Usual Oc	cupation one during most	t of working		16b. Kind of E	Business/In	ndustry	
nen "	nple	Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	DO NOT use re	work En	_		Priva	te		
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ntal H	Be	17. Father's Name (First, Middle, L	ast)				-		First, Middle, M	Maiden Suma.	me)		
d Me mark	မ	Selwyn Siegel 19a. Informant's Name/Relationsh	in (Type Print)		10h Mailie	na Address /Ctr	Tan reet and Numbe	net Gr		City of Tour	Ctata Zi	n Codel	
than than tyle:		Janet S. Liebe	, , , , ,	lother		•	Terrace					20854	
Heal Heal tem 2	. 1	20a. Method of Disposition			Place of Dispo	sition (Name o	f	Date		20c. Location		own, State	
ages and of all is	1	1 Ø Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			-	matory or other	Garden	- 1/19				, Virgi	inia
artme ortan Injur		21. Signature of Funeral Service L		K.									ша
Depar Impor eny Ir		Domald C.	Stat	He mare	es D	anzansk	ddress of Facility cy-Goldb ckville	berg M	femoria Rocky	1 Chap	els,	Inc.	852
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the dea							IIdiyi	Approximate	
turisina		Immediate Cause (Final	nly one cause on	each lin		$\Lambda +$	T T	7	1			Interval Betwee Onset and De	en eath
hysician /Medical		disease or condition resulting in death)	a. Due to	(or as a conse	equence of):	12	ery 1		mb as a		-		
xaminer			A	terios	dent	ze Car	didia	scola	-0	iceai	8		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence of):	<i>y</i> = 3 ,		J C 4-	7 2	2004			
physicien and the burial-transit	Examiner	that initiated events	c										
ien au urial-t	EX	resulting in death) Last	Due to	(or as a conse	equence of):								
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e as		IF FEMALE:						· · · · · · · · · · · · · · · · · · ·					
signed by the attending p d be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 ☐ Fet	tal death 3[Ectopic pregna					ate of delive	ery Day Ye	ar
the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unki	nant at time of	death 5	Other (specify	")			,,,,	OH (I)	Day 10	u.
d by Jetac		Part II. Other significant condition	15 contributing to	death but not re	sculting in the u	ndochring cause	count in Part I		23a Did tob	22000 HEQ COR	stributa to t	he cause of dea	ath?
signe d be	by	, u	io community to	30411 000 1100 10	January III tile u	noonying cause	giverrai i aiti.			s 2 No	3 Prot		
should	etec								· · · · · · · · · · · · · · · · · · ·		~		
ste hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ompleted								24a. Was at autops	y	Were auto prior to co death?	opsy findings av Impletion of cau	allable ise of
icete	O									No No		2□ No	
recto	Be	25. Was case referred to medical examiner?	Hospital:			T	Other		eck only on				
ral di	<u>유</u>	1 No 27. Manner of Death	1		ZR/Outpatier 28b. Time o	II 3 DOA	4 🗆 1901		5 Reside			fy)	
After fune	ig l	Natural 5 Pending		of Injury oth, Day Year)	Injury		njuryat Work? 1 □ Yes 2 □ N		J. Describe IIO	w injury occu	1100		
deati ctor; y the	Certification;	3 Suicide 6 Could n	ot be 200 Place	e of Injury - At I	home farm etr				Location (St	reet and Num	her or Rum	al Route Numbe	
after Dire	erti	4 ☐ Homicide determine	hed build	ding, etc. (Spec	city)	eet, raciory, oin	ice	251	City or Town	, State)	Dei Oi muit	ar modio radilibe	<i>''</i> ,
within 24 hours after death. To the Funerel Director, After this certificate hes completely filled in by the funeral director, page 2		29a Certifier 1 Certifyin	Physician: To th	e best of my kn	towleday 1 un	s opportunit as the	e time date an	d stroy and	f dua to the ex	turidet a st	N. Walle and a	tratest	
Fui e Fui etely	edical		xaminer: On the	basis of examin	nation and/or in	vestigation, in n	ny opinion, deat	th occurred	at the time, da	ate and place,	, and due to	o the cause(s)	
within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	2			29c. Lic	ense number		29	9d. Date signe	ed (Month,	Day, Year)	
LN		Y)/ Last	DAMA)		0	CME		T	anuary	16 '	2006	
τ	1	30. Na mand address of person w	tho completed cau	use of death (Ite	em 23a) (Type.		O. III		JUE	muat y	10, 4	2000	
		T. Alow Lo	cke, N	0			Penn St	reet :	Baltimo	ore, Ma	arylaı	nd 2120:	1
Sta	e	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature								
Sta Registra		JAN 2 0	2006	nogistrar's Sign	Is a	antis							

			For State Registrar		aryland / De		nt of H	leaith and N	lental Hy		9	03604
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De			3. Time of Death
*	Physici /Medic Examin	al	WALTER JOSEPH S 4a. Facility Name (If not institution, gr	HERWIN		4b. City,	Town, o	r Location of Death	Month Januar	_		11:25 A M
	LAdimir		Manor Care of Po	otomac		Poto	omac			Mot	ntgomer	7
	Funeral Director		5. Social Security Number 6. 394-24-8189	1107 M 207 E	e (In yrs. last birtho	Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	rth ay, Year)	9. Birth	place (State or Foreign intry)
	Pu ,		Usual Residence of Decedent		40- O't- T-							
	e Maryla	ctor	MD 10a. State 10b. County MD Montgot	nery	Bethesd							10d. finside City Limits 12□XYes 2□No
	th with th	ai Dire	10e. Street and Number 7017 Arandale Re	oad		10f. Zip 208					zen of What Cou ed State	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itsm 27 is marked other then "naturel; or iteme 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at other traumatic avent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 253 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:	Ever in U.S.	13. Was Deced If Yes, spec		lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	ļ	14. Race - Amer Black, White Specify: W	
5-0	72 ho	eted	15. Decedent's l (Specify only highest g		16a. D	ecedent's Usua	at Dccup	ation during most of work	ang	16b. Kir	nd of Business/l	ndustry
21215-0036	should be filed within and Mental Hygiene. s marked other then " sumatic avent, the Me.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work Developm		USA	ID/Fede	cal Gov't.
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle	, Maiden	Sumame)	
Z	Men Men Marke Marke	T ₀	Monroe Schwerin					Mariann				
Maryland	d 2 sho h and 7 is mu trauma		19a. Informant's Name/Relationship Kitty Sherwin,					and Number or Rui				p Code)
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If Itsm 27 Is any injury or other trau		20a. Method of Disposition 1 \(\sum_{\text{NBUrial}} 2 \sum_{\text{Cremation}} 3 \)	☐Removal from State	20b. Place of D cemetery,	isposition (Nai crematory or o	me of other plac	ce)	Date	20c. Lo	cation - City or T	
Ħ	it. Pa		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lig		Grdn of				2-2006		rksburg	
Ba	permit. Departr Importe any inje		Qual Qual	6 our	\mathfrak{O}			Hampshire				Home Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each li	the death. Do not no.	2 (de of dyin		or respiratory a	arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed obysician and the burial-transit	dicai Examiner	Sequentially list conditions, I any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)	:						
.O. Box 68	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 DEctopic p		1		2	23d. Date of deli-	very Day Year
Q	w requires that i been signed by should be deta	by	Part II. Other significant conditions	contributing to death t	out not resulting in the	ne underlying o	cause giv	ren in Part I.				the cause of death?
Records,		Completed							24a. Was auto perf 1 Yes	s an	24b. Were au	opsy findings available ompletion of cause of
Vital	ysicien: Th his certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			100	26. Place of Dea	th (Check only	one)		
of	this aldi	- To	1 Yes 2 No	1fnpati	· · · · · · · · · · · · · · · · · · ·			430 Nursing H			6 □Other (Spec	ify)
Division	ding After fune	cation	1 Auturaf 5 Pending 2 Accident investigat 3 Suicide 6 Could not	ho	y Year) Inju	M M		yat k? Yes 2 □ No	28d. Describe	now injur	у оссиггеа	
Divi	rs after d el Direct	Certifi	4 Homicide determine	d 286. Place of in	jury - At home, farm tc. <i>(Specify)</i>	, street, factor	y, office			(Street and own, State		ral Route Number,
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Exone)	Physician: To the best aminer: On the basis of and manner st	of examination and/	death occurred or investigation	at the tir n, in my c	me, date and place opinion, death occur	, and due to the rred at the time	cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifier	1/2	1		c. Licens	se number		29d. Dat	e signed (Month	Day, Year)
	18		30. Name and address of person wh	completed cause of	death (ftem \$3a) (Ty	/pe, Print)	-				1-11	2000
			Anushiravan Dadg	ar-Dehkord	i, MD 132	219 Exe	cuti	ve Park '	Terrace	Gern	nantown	MD 20874

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2006

32 Registrar's Signature

			For State Registrar	State of	Maryland /		tment of He			iene	6 (3605
	Physicia /Media		1. Decedent's Name (First, Middle	RATMOND			TT		2. Date of Dea Month JANUAR	Day 17	Year Zeo (3. Time of Death
	Examin	er	4a. Facility Name (If not institution Anne Arundel M				4b. City, Town, or Lo Anna	apolis	1	4c. County o	of Death 1e Ari	undel
	Funeral Director		5. Social Security Number 212-60-9388	6. Sex 7. 1 ★ 2 □ F	Age (In yrs. last b	irthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jun. 10	Year)	9. Birthpla Countr	ice (State or Foreign y) MD
	Iryland show		Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	10c. City, Tov	wn or Loca		na Park			100	d. Inside City Limits
	h the Ma r 28e-f	Director	10e. Street and Number	AL UTICET			10f. Zip Code	ia raik	1	0g. Citizen of W	/hat Countr	1 □ Yes 2 🛣 No y?
	ath wit		200 Avondale (Circle			211			US	SA	
036	within 72 hours after death with the Maryland one. Than "netural; or items 23a or 28e-1 show the Modical Examinar must be notitled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ※ Divorced	12. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dat	es? ⊠No		as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2⊠ No	eanic Origin? (S Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		e - America k, White, et : Whi	tc.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Manhal Hygiene. Is marked other than "netural", or liems 23a or 28e-1 show aumatic event, it e Modical Examinar must be notified at	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	for 5+)	(Give ki life. D	nt's Usual Occupation of work done dur O NOT use retired) Architect	on ing most of wor	king	Johns Hosp		
yland ;	should be filed and Menta! Hygid s marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Powell "Raymond		Jr.				ne (First, Middle) Senevieve			
Mar	ウモアキ		19a. Informant's Name/Relations Tim Staines/Sor		19		Address (Street and Ternwing			-		Code)
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 2005		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other (S)		ate cemet	ery, crema	tion (Name of atory or other place) ematory		Date 19,	20c. Location - 0		
Balti	permit. Departn Importa any nju		21. Signature of Eugeral Service	Licensee		Bar	Name and Address Cranco & S GOV. RIL	of Facility	A. Sever	na Park	Func	ral Home
3	Physician		23a. Parl 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	used the death. Do	not enter					í	Approximate nterval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	Due to (or	r as a consequence	e of):						
,0,	cate be executed hysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Indentying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequence							
68760	ificate be g physica s the bu	edical		d								
O. Box	It the death certificate be executed by the at ending physician and tacled for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	1 Live birt	ome of pregnancy th 2 Fetal deat nt at time of death vn		Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery	/ Day Year
rds, P.	quires that n signed by uld be deta	by	Part II. Other significant condition	ns contributing to dea	th but not resulting	in the unc	derlying cause given	in Part I.		. 4		cause of death?
Records,	The law requires that ate has been signed b page 2 should be deta	Completed							24a. Was a autops perform	ned? d	eath?	sy findings available pletion of cause of
Vital	yslcien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						th (Check only or			
	hys this al di	n; To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 11 Ing		Time of	3☐ DOA Other: 28c. Injury a Work?	4	ome 5 Reside			
Division of	To the Hospitel or Attending Physicien: white 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification;	1 Natural 5 Pendin investig 3 Suicide 6 Could determ	gation not be 28e. Place o	of Injury - At home,	Injury farm, stree	M 1 □ Ye	s 2 No	28f. Location (S	reet and Numbe	er or Rural i	Route Number,
ā	i Si fe		4 Homicide	Duliding	g, etc. (Specify)	an death			City or Town			
	To the Hospitel or within 24 hours after to the Funerel Dirac completely filled in b	edical	(Check only 2 Medical one)	g Physician: To the b Examiner: On the bas and manne	is of examination a	ge, death o	estigation, in my opin	ion, death occu	rred at the time, d	ate and place, a	ind due to t	he cause(s)
	with To To	Σ	29b. Signature and title of certifie	1 Am			29c. License n	S63	J	9d. Date signed	(Month, D	
			30 Name and address of person	1	1/	(Type, P	rint) Hasi	P. PAZ	BacT.	not s	M	84MNA
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3		gistrar's Signature	A	and)					

Baltimore, Maryland 21215-0036

within 24 hours efter death.

To the Funerel Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

11			riease							Are Legible.		
		For State		State of Ma	arytant					2006	03606	
		Registrar Certificate of Death								109.110	3 Time of Dooth	
Physicia /Medic	-	1. Decedent's Name (First, Middle, Last) John Richard Simmons, Jr.							Month Januar	Day Year	3. Time of Death 2:50 P M	
Examine	_	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death			4c. County of Death		
		758 Dividing Road					Severna			Anne Arundel		
Funeral Director		5. Social Security Number 217–92–3186 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 28 Yrs. 7. Age (In yrs. last birthday) 28 Yrs. 7. Age (In yrs. last birthday) 30, 1977 9. Birth (Month, Day, Year) 30, 1977								thplace (State or Foreign buntry) MD		
death with the Maryland ma 23a or 28a-f show rmat be notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit									Tank India Charles	
	tor	MD Anne Arundel				, rown or Lo		rna Park			1 ☐ Yes 2 🛣 No	
or 28	ire	10e. Street and Number	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?	
72 hours after death wi natural, or Itema 23a dical Examiner must b	a	758 Dividing Road						1146			JSA	
	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		1 ☐ Yes 2 ☐XNo			Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White		
72 ho	ted	15 (Specify)	5. Decedent's Edu	cation 16a. Deced			dent's Usual Occup	ation during most of work d)	kina	16b. Kind of Business	ind of Business/Industry	
F . C	Completed	Elementary/Seconda					Mechanic		ang	Service Center		
E T # E	BeC	17. Father's Name (Fire	st, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Surname)		
	2	John Richa	rd Simmo	ns, Sr.				Virginia	a Flynn			
1 and 2 sh Health and Im 27 is m ther traum		19a. Informant's Name/Relationship (Type, Print) Virginia Simmons/Mother					. Mailing Address (Street and Number or Rural Route 758 Dividing Road, Seven					
		1 Burial 2 Cremation 3 Removal from State				metery, crer	esition (Name of matory or other place ematory	Jan,	Date 21, 2006	20c. Location - City or Town, State Baltimore, MD		
permit. Pages Department of t important: if its eny injury or or once.		21. Signature of Private Service Licensee Barranico des Sonis, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146										
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition resulting in death) a. LONTACT GUNLIGT WOND OF HEAD Due to (or as a consequence of):							HEAD		Onset and Death	
/Medical									1004112			
Examiner		Sequentially list condit	tions	b								
D ::	Examiner	Sequentially list condit it any, leading to imma cause. Enter Underlyin Cause (Disease or inju-	а сопвыци	anes ut):								
be executed sicien and burial-transit	каш	that initiated events resulting in death) Last		c								
bur bu	calE			ous to to as a surroquative or).								
cate physi the l				d								
law requires thet the death certificate as been signed by the attending physions should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown				death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delivery Month Day Year		
thet ted by detail	선								acco use contribute to the cause of death?			
uires Isign Id be									1 🗆 Y	Yes 2 ØNo 3 ☐ Probably 4 ☐ Unknown		
w requ	ete	24a. Was an 24b. Were autopsy findings available										
The law sete has page 2 :	• Completed								autop perfo	sy prior to death?	completion of cause of	
sician: T certificeta rector, pa		25. Was case referred to medical 26. Place of							1,23.Yes th (Check only o		No D⊠Yes 2□No	
Physicia this cert ral direct	To Be	examiner? 1⊠ Yes 2□ No		-fospital: 1 □ Inpatie	nt 2∏E	R/Outpatier	t 3C DOA Oth	00		lence 6 XOther (Spe	schi scene	
g Phy er thi		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b determined		28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe ho					ow injury occurred			
Attending Physician: or death. ector: After this certific by the funeral director.	atio			(Month, Day Year) Injury			M 1 🗆	Yes 2,⊠No	SUBTECT	LF		
P = = =	Certification:											
To the Hospital of within 24 hours of To the Funeral D completely filled in		2Ja. Certifier (Check only (Ch										
thin 2 the I	Medical	one) and manner stated.								29d. Date signed (Month, Day, Year)		
Z M C O		29b. Signature and title of certifier				29c. License number				January 19, 2006		
		OCME January 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								2000		
		ANA RUPIO HD 111 Penn Street, Baltimore, Maryland 21201										

State Registrar

31. Date filed (Month, Day, Year) JAN 2 3 2006 A Aposto

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	ate of D	eath	R	eg. No.	0 03607	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	th	3. Time of less th	
Physicia /Medic			Ronald Franci						30°, 200°	6 4:00 am		
	Examir	ner	Ab City Town or lo							of Death 4c. County of Deeth Carroll		
į	Funeral Director		5. Social Security Number 6. Se 220-54-1098		ge (In yrs. last birthday) 55 Yrs. If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. Fe				8. Date of Birth (Month, Day) Feb 28,	1950 W	Birthplace (State or Foreign Country) ashington DC	
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	e Maryk 8a-f sho pitted a	ctor	Maryland Carroll		Finksburg				g	1 ☐ Yes 2 No		
	ath with the 23a or 2 west be no	Funeral Director	1505 Marie Court		10f. Zip Code 21048					at Country? A		
21215-0020	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 □ Yes 2☒ No Specify:					ecify Yes or No- Rican, etc.)	American Indian, White, etc. White		
	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)				ring	16b. Kind of Busin	ess/Industry		
121	within ene. then '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	ege (1-4or 5+) Sales Associate				Department Store			
arylan	filled Hygie Sther		17. Father's Name (First, Middle, Last)					8. Mother's Nam	ame (First, Middle, Maiden Sumame)			
	lid be lental ked c	To Be	Herbert William	Trageser,	Sr.			Marga	ret Anne	e Farrell		
	i end 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other then "! other treumatic event, the Mes		19a. Informant's Name/Relationship (T) Margaret L. Gurio						_	r, City or Town, Sta MD 21048		
	permit. Pages 1 end 2 Department of Health a Importent: If item 27 Is eny Injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of cemeter,	Disposition (A v, crematory o Carrol	r other place)	atory 0	2/01 2006	20c. Location - Cit Winfiel		
Balti	permit. Departm Importe eny Inju										neral Home 21157	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Physician /Medical Examiner	Immediate Cause (Final ACUTE MUSICAR DIE! (AFARC'TION MIN								Onset and Death MINUTES		
		ē		Du	ue to (or es a c	onsequence o	f):					
Pot:	cuted nd ransit	Examiner	b. Due to for as a consequence of:									
Ő,	e exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
x 68760,	eath certificate be executed ettending physician end for use as the buriel-transit	Medical	that initiated events resulting in death) Last Due to (or as a consequence of):									
		lan/	0.									
o.	res that the death signed by the etter I be detached for u	Physiclan		ntributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobecco use contribute to the ceuse of death?			
Δ.	that ned by deta	by Pt							1 Yes 2 No 3 Probably 4 Unknown			
Records,	requi	Completed b							24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?			
Ä	sicien: The law certificate has b lirector, page 2 s	E							1 = Y	e6 2 □ N C	1 Yes 2 16	
/ita	ysicien: is certifica director,	Be (25. Was case referred to medical examiner?					26. Place of Death Check only one				
of Vital	2 .00 C	٦.	10 165 2006	lospital:	1			4 Li Nursing no	Home 5 Hosidence 6 Other (Specify)			
	Attending Ph ir death. ector: After th by the funeral	catlon:	27. Manner of Death 1 Natural 5 Pending investigation	(Month, Day Y	a. Date of Injury (Month, Day Year) 28b. Time of Injury			es 2 🗆 No	28d. Describe how injury occurred			
DİVİ	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by	edical										
	To the complete compl	ž	29b. Signature and title of certifier 29c. License number						2	29d. Date signed (Month, Day, Year)		
	50		Del Kosestraun, M.D. 009874 1/30/06								96	
_	N° 5		30. Name and address of person who co	15AUN	3720	Type, Print)	RAGU	TAVE	. KENS	MOTON	1 MD 20895	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Flagistrar's	Signature	60216						

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			- State RegistrarAmend#19b.Pe	State of Maryland					Mental Hy	1		03609
,cog	,		RegistrarAmeno#190 Pe 1. Decedent's Name (First, Middle, Last)	LIAM.FGC Z-I-		uncal	0, 00	- COLIT	2. Date of De	Reg. No.		3. Time of Death
	Physici /Medic	al -	DONALD I			1			Januar	y 21	,2006	7:50 A M
ando	Examin	er	4a. Facility Name (If not institution, give s Southern Maryland			4b. City,		cation of Death	1		County of Dea	
	Funeral	X	5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under Months	1 Year If	Under 24 Hrs.	8. Date of Bi (Month, Di	rth av. Year)	9. Bir	thplace (State or Foreign
2.	Director		579-26-1441 1 XI	^{M 2□ F} 78	Yrs.				Dec. 2	3,1 <u>9</u> 2	27 Mar	ylánd
	Maryland I-f ehow fied at		10a. State 10b. County Prince Geo		nton	ocation						10d. Inside City Limits 1 Yes 2 No
	h with the	al Director	10e. Street and Number 5912 Woodland Lane	2		10f. Zip 20	735	_			izen of What Co USA	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Haalih and Menial Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, spec	dent of Hispa cify Cuban, N 2. I No S	Aexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ami Black, Whi Specify: Wh	te, etc.
15-0	n 72 ho •natur • dical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give	dent's Usua kind of wo	al Occupation	n ng most of wor	king		ind of Business	
212	d within giene. or than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Const	ructi	on Eng	gineer		Fed	eral Go	v't.
land	buld be filed Mental Hygid arked other atic event, I	To Be (17. Father's Name (First, Middle, Last) Charles D. Thompso	on					A. Pie		Sumame)	
Mary	id 2 should be the and Mental 27 is marked (traumatic ev		19a. Informant's Name/Relationship (Type Carol A. Thompson)		5012	17 11	J T -	014	ral Route Numb	5 700	or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	Pages 1 and 3 nent of Haalth int: if Item 27 iry or other tr		20a. Method of Disposition 1 ঐ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	sinovat nont State	ace of Dispo emetery, crei	osition (Nar matory or o	ne of other place)		Date 6/2006	20c. Lo	ocation · City or	
Balti	permit. Page Department of Important: if any injury of		21. Signature of Funeral Service License		22	2. Name an	nd Address o	f Facility C	edar Hill Suitland	Fune	ral Home,	
*	Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line. Aspiration			le of dying, s	uch as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death Minutes
1. S. C.	/Medical Examiner	_	resulting in death) Sequentially list conditions,	Due to (or as a consequence Dysphagia								months
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Apoplexy	ionica orj.							years
68760,	ficate be executed physician and is the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a consequ Hypertensic								years
O. Box	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3[⊒Ectopic pi ⊒ Other (sp					23d. Date of de Month	livery Day Year
<u>a</u>	quires that n signed b uld be deta	Ď	Part II. Other significant conditions con Atrial Fibrilla	•	-	inderlying o	ause given i	n Part I.		tobacco		o the cause of death? robably 4 ÖdUnknown
of Vital Records,		Completed							24a. Wa auto per 1 🗆 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of s 2 12 No
Vit	ysician: T is certifical director, p	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 및 No	ospital: 1 ☑ Inpatient 2 ☐ I	ER/Outpatie	nt 3 🗆 DC	Other		ath <i>Check only</i> Iome 5□ Res		6 □Other (So	acifu)
	ng Ph fter th neral	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?	2 No	28d. Describe			sury j
Division	al or Attendi s aftar death. i Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		treet, factor	y, office		28f. Location City or To			lural Route Number,
	To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deat tion and/or in	th occurred nvestigation	at the time, n, in my opini	date and place ion, death occu	a, and due to the urred at the time	e cause(s), date an	s) and manner a d place, and du	s stated. e to the cause(s)
	To the To the comp	W	29b. Signature and title of certifier Mulliant	Puntel	110		c. License ni MDHOO4				ate signed (Mon	th, Day, Year) 25, 2006
2	(10)		30. Name and address of person who co Michael Pimentel,	moleted cause of death (Item	23a) (Type.	. Print)	ad 1-1	A Waldo			-	
1	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture	A.						

			For Stata Registrar	State of M	arylan				lealth and Death	Mental I	lygier Reg. t	ZIIIIb	03610
	Physicia		1. Decedent's Name (First, Middle, Last) Beverly T							2. Date of Month Janua		Day 2006	3. Time of Death 3:55A M
)	/Medic Examin		4a. Facility Name (If not institution, give		1				Location of Deat			4c. County of De	ath
	Funeral		Holy Cross Hospit 5. Social Security Number 6. Sec	7. Aç	ge (In yrs. I	ast birthday)	If Unde	r 1 Year	Spring If Under 24 Hrs	8. Date of	Birth	Montgom	irthplace (State or Foreign
	Director		579-50-1135]M 21119F	68	Yrs.	Months	Days	Hours Min.	Sept. 2	20, 1	937 Was	shington, DC.
	ryland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	the Ma 28a-f	ecto	Maryland Montgomer 10e. Street and Number	У	Si	lver Sp		Code			10a. (Citizen of What (1 Yes 2 No
	23a or	al Di	12905 Chathlake L	ane					20904			nited S	
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show avent, the Madical Examical more to notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 1 If Yes, Give Year or Dates:	?		Vas Dece Yes, spe		ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or to Rican, etc.	No-	14. Race - An Black, Wh Specify: E	
21215-0036	n 72 ho "natur	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usu	al Occupi	ation during most of wo	rking	16b.	Kind of Busines	s/Industry
N	d withir giene. er then	Somp	Elementary/Secondary (0-12)	College (1-4or	5+)	Teache						Educatio	on
Maryland	ouid be filed Mental Hygid arked other atic svant, II	Be	17. Father's Name (First, Middle, Last) Thomas Weems						18. Mother's Na Helen	me (First, Mic Harris		en Sumame)	
ary	and and sum	၉	19a. Informant's Name/Relationship (Ty			1.	_		and Number or R	ural Route Nu	mber, City		
	1 and 2 Health em 27 sther tra		J. C. Thomas/Husb	and ——————	20b. PI	lace of Dispos	sition (Na	me of	e Lane;	Silver	-	ing, MD.	
altimore,			1 A Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			emetery, crem irrecti	-		ery Jan.	31,2006			
Balt	permit. Page Depertment of important: if any injury or ance.		21. Signature of Funeral Service Licens	Ekell					E	orestv	ille	l Homes ro Pike , MD. 2	20747
	Ob.,i.i.i		23a. Part1. Enter the disease, or combine shock, or heart failure. List only or immediate Cause (Final				er the mo	de of dyin	g, such as cardia	c or respirator	ry arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as									
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	uence of):							
	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	5. Duals (22.22									
58760,	cate be executed physicien and the burial-transit	dicalE		Due to (or as	a consequ	ience or):							
	= = =		IF FEMALE:	3c. If yes, outcome	of program	200							
	at the deeth certific by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 27 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s				-	23d. Date of d Month	elivery Day Year
ds, P	gne be d	Ď	Part II. Other significant conditions con	ntributing to death b	out not resu	ulting in the un	nderlying	cause givi	en in Part I.				to the cause of death? Probably 4 Munknown
Records,	iaw requir as been s 2 should	Completed								24a. V	utopsy	prior to	autopsy findings available ocompletion of cause of
a R	ician: The lav certificate has rector, page 2:	e Con	25. Was case referred to medical						00 81	1 □ Ye	erformed? s 2√2!	death?	es 2□No
<u> </u>	S 5 5	To B	examiner?	lospital: 1 ₺ Inpati	ent 2 🗆 E	ER/Outpatient	1 3 D	Oth	26. Place of De er: 4 ☐ Nursing I			6 ☐Other (Sp	ecify)
ono	ing Affe	tlon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury	м	28c. Injury Worl 1 □	yat k? Yes 2 □ No	28d. Descri	be how in	jury occurred	
É	7 9 5 5	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, stre	eet, factor	y, office			n (Street Town, Sta		Rural Route Number,
	To the Hospital of within 24 hours of within 24 hours of the Euneral D completely filled in	Medical (29a. Certifier 1⊠ Certifying Physical Control (Cineck only one)	sician: To the best ner: On the basis of and manner st	t examinat	wledge, death ion and/or inv	occurred	at the tim	ne, date and place pinion, death occi	e, and due to urred at the tir	the cause ne, date a	(s) and manner a and place, and do	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of pertities	and maillel si	N - C		29	c. License	e number		29d. E	Date signed (Moi	nth, Day, Year)
)	(4)		1009	Us.	216			4547	1		Jar	nuary 24	, 2006
X	00		30. Name and address of person who or Yeheyis Negussie,	/				; Si	lver Spr	ing, M	D. 2	20910	
	Sta Registr		JAN 2 6 2006	32. Registr	rar's Signat	ture							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January Pa, 2006 an 4:15pm M Edith Wood Thiers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgomery 4b. City, Town, or Location of Death Chevy Chase Examiner Manor Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Schooth, Day Year 915 9. Birthplace (State or Foreign Months Days Hours 90 Min 440-03-3325 1 ☐ M 2 🗓 F Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral', or Items 23a or 28a-f show LExaminer must be notified at Completed by Funeral Director 1X Yes 2 □ No DC Washington DC None 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 Massachusetts Ave, N.W. #1008 20016 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itel ury or other traumatic event, the Medical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real estate Broker/Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fox Wood Elsie Burton ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3031 Cambridge Place, N.W. Washington DC 20007 Burton C. Wood/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pages 1
Department of He
Important: If iten
any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1-26-06 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC Were weekeld 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic ung Cancer. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Wunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed: 2 X No 1 Yes 2 No 1 Tyes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566 1/15/06 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitea Bhogavilli 1220 A East Toppa Road Seit 230, Towson, MD21286 31. Date filed (Month, Day, Year) JAN 24 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 20 2006 **Physician** TOHN TRIPLET 1715 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL DLNEY MONTGOMERY If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 229.34.2859 72 Director July 10, 1933 Alexandria, VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rthen "naturel", or iteme 23a or 28e-f ehow the Modical Examiner must be nutitied at 10d. Inside City Limits Maryland 1 Yes 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13008 Morningside Lane 20904 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No 1953
If Yes, Give
Year or Dates: 1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) 12th Insurance Agent Insurance injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other eny injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John W. Triplett, Sr. Anita Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne B. Triplett/Wife 13008 Mormingside Lane, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cem. 1/25/2006 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses HINES-RINALDI FUNERAL HOME, INC. Nonce 23a. Part1. Enter the disa, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high relations. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** SEPTICEMIA < I WEEK /Medical Due to (or as a consequence of): Examiner < I WEEK CHOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of defivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PANCREATIC ADENOCARCINDMA 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2□ No Be 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ۲ 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death Certification: 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 TYes 2 TNo 2 Accident investigation efter death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours e 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D62656 HOSPITALIST JANUARY ZI 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 PHINCE PHILIP DRIVE, DLARY MARYLAND 20832 SONIA HOLMES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 24 2006 Registrar

			1 - For State Registrar	State of M	arylan		artment tificate			ind M		iene eg. No.	06	036	13
	Physici		Decedent's Name (First, Middle, Last, Minnie Alice Tete						-		2. Date of Dea Month Januar	Day	Year 2006	3. Time o	Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number,)		4b. City,	Town, or	Location o	f Death	Januar		inty of Death	3.07	A
			Memorial Hospita	1				mber				A1	legany		
	Funeral Director		213-30-6067	7. A	ge (In yrs. I 69	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Nov 9	1936	9. Birtho Mary	lace (State of	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							0d. Inside C	ity Limits
	Mary Feb	tor	MD Garrett		Gr	antsvi	lle							1 🗌 Yes	2 X No
	or 282	Director	10e. Street and Number				10f. Zip						of What Cour	itry?	
	ath w	rail	761 Meyersdale Ro						1536				USA		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ehow any njury or other traumatic event, it is Modical Examinant to notified at QDGs.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 H If Yes, Give Year or Dates:	?	1	Was Deced IYes, spec I□Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:		
ည်	72 hou	ted	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	lent's Usua	l Occupa	ition	of workin	10	16b. Kind o	f Business/in	dustry	
2	Athin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us	e retired;)	GI WOINII	'9		rm Hom	_	
22	Hygiel ther th	S	9 th 17. Father's Name (First, Middle, Last)			Homem	aker		18 Mothe	r's Name	(First, Middle,		wn Hom	e	
yland	ould be i Mental I arked o	To Be	George Spiker								Merrbac		74170)		
, Mar	and 2 shoath and 27 is m		19a. Informant's Name/Relationship (Ty Gladys M. Merritt			1					Route Number antsvi		_		
Baltimore, Maryland 21215-0036	Pages 1 and of He and of Item and: If Item arry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1 ~	ace of Dispo metery, cren rrbach	natony or of	har nlare	Jan		2006		on - City or To sville		
Balt	permit. Dep. dr. Importe		21. Signature of Funeral Service Licens	unal	1						ntsvil				
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Tylethic	phylo	collu	6				r respiratory arr			Approximatinterval Bet Onset and	tween Death
š	Examiner	<u>_</u>	Sequentially list conditions,	Seps Due to (or as	IS					_11(BIVE	185
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to () r as	ina	OLL	fa	ilu	12				3	3Wee	ks
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O. Box 6	The law requires that the death certific 11e has been signed by the ettending p 2age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pre					23d.	Date of delive		Year
ds, P	uires that signed to id be deta		Part II. Other significant conditions con	tributing to death t	out not resu	Iting in the ur	ndertying ca	ause give	n in Part I.	1		bacco use c	ontribute to th	ne cause of o	
Division of Vital Records,	e law requir has been si je 2 should	Completed by					7				24a. Was a	sy	b. Were auto	psy findings	available cause of
a H											perfor	med? 2 No	death?	2 2 No	
Ę	siciar certif irecto	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:				Othe			(Check only or				
ō		n: To	27. Manner of Death	28a. Date of Inju	Jry	R/Outpatien 28b. Time of		Bc. Injury Work	4 LI NUI		ne 5 Reside			()	
Ö	Attending Physician: r death. sctor: After this certifict by the funeral director.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly rear)	Injury	м		? ′es 2 ☐ ħ	No					
Divis	al or Attending s after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (S. City or Town	reet and Nun, State)	imber or Rura	l Route Nun	iber,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	of examinat	vledge, death ion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the c	ause(s) and ate and pla	manner as si ce, and due to	ated. the cause(s	5)
	To the H within 24 To the F complete	M	29b. Signature and title of certifier	Na	ma	by	29c.	License	number 3655	5	2	1	ned (Month,		06
			30. Name and address of person who co	mpleted cause of	death (Itell)	3a) (Type,	Print)	1	gmi	ntSVi	11e, M				
	Sta	te	31. Date filed (Month, Day, Year)	2877	rar's Signat	ure	4 176		1100	1 1 40 8 1	:	01/			
	Registr	ar	JAN 2 7 2	2008	Prose o	M	Aneral R	\$							

ORIGINAL

			1 - For State Registrar	State of Ma			ent of H			P	Reg. No.	006	03614
75	Physici	an	Decedent's Name (First, Middle, Las	(t) Charles Fu	lton Taylo	r				Date of Dea Month	Day	Year 06	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give		iton Taylo		City, Town, or	Location of D	Death	VI	4c. C	County of Dea	ith
			SACRED HEAR	T HOSPI	ML	C	UMBER	LAND			B	LLEGF	NY
	Funeral		5. Social Security Number 6. Security Number 1. Sec		(In yrs. last bin	thday) If U Yrs. Mon	nder 1 Year ths Days	Hours h	Hrs. 8.	Date of Birth Month, Day		C	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		84					January	05, 1922	2	Maryland
	how	_	10a. State 10b. County		10c. City, Town	n or Location							10d. Inside City Limits 1 ☐ Yes 2 No
	Sa-f	Director		egany		T		Lonaconi	ing		10- 03-		<u> </u>
	with t	Dir	10e. Street and Number 15912 St. Mary's	Church Terrac	e S W	101	. Zip Code	21539			rog. Citizi	en of What C	S.A.
	n 72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f ehow edical Exerciret must be notified at	Funeral	11. Marital Status	12. Was Decedent E		13. Was D	ecedent of Hi specify Cuba		? (Specify	Yes or No-	10	4. Race - Am	erican Indian,
9	or ite	/ Fui	1 ☐ Never Married 2 🌠 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give	0		specify Cuba	Specify:	ueno nica	iii, 0 10.)		Black, Whi Specify:	
21215-0036	hours lure!;	d by	3 Widowed 4 Divorced	Year or Dates:	160								White
5	- 1	olete	15. Decedent's Ec (Specify only highest gra	de completed)		(Give kınd o life. DO NO	Usual Occupa f work done o Tuse retired,	luring most of)	f working		I DD. KIN	d of Business	undustry
212	d within giene.	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5-	r)		Rout	e Supervi	isor			Reta	il Sales
pu	be filed ntal Hygie of other	Be	17. Father's Name (First, Middle, Last)					18. Mother's	10.				
ryla	should be ind Mental marked o	10	19a. Informant's Name/Relationship	omas Hamill Ta		Mailine Ada	ress (Street a	and Alumboro				eth Eisen	
Maryland	d 2 th a		Margaret Tay		190	•	,						MD, 21539
	es 1 an of Heal f item 2 r other		20a. Method of Disposition		20b. Place of	f Disposition			Date			ation - City or	
E C			1 ¥ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				morial P			ary 24, 006	C	umberlar	nd, Maryland
Baltimore,	permit. Pag Depertment Important: eny injury c once.		21. Signature of Funeral Service Licen	<i>U</i> •		22. Nam	e and Addres Eichhorn			eal Hom			Main Street,
4	, 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r	not enter the	mode of dying	g, such as car	rdiac or re	spiratory ar	rest,		Approximate Interval Between
1.5	Physician		Immediate Cause (Final disease or condition	a. Esol	PHAGEA	IL C	JARC,	MON	14				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):							-
6	po ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):					-		
	The law requires that the death certificate be executed ate bas been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence	of):							
8760	e be e sician e buris	ical	· ·	d.									
9	tificate og phys as the		IS SCHOOL STATE OF THE SCH										
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	2 Fetal death		ic pregnancy				23	3d. Date of de Month	elivery Day Year
0.	at the de by the a tached f	ysic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 ∐ Othe	r (specify)						
<u> </u>	res that I igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the underly	ing cause give	en in Part I.		23e. Did to	bacco us	e contribute t	to the cause of death?
Records,	n require: been sig should b		COROWARY	ARTERY	1 DI	SEAS	<u> </u>			1 🗆 Y	′es 2□	No 3□P	Probably 4 Unknown
eco	e law re has be	Completed								24a. Was autop	sy		utopsy findings available completion of cause of
<u>=</u>		Con									rmed? 2 No	death? 1 ☐ Ye	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of					
of	Phys arthis araldi	1:10	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b.	Time of	28c. Injury Work	4 🗆 140131		5 Resid		Other (Special occurred	ecity)
ion	Attending in death.	ation	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day	Year)	ln i ury M		<br Yes 2 □ No	,				
Division	al or Attandation after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc		arm, street, fa	ctory, office		28f.	Location (S City or Tow	Street and vn, State)	Number or F	Rural Route Number,
	To the Hospital or Attan within 24 hours after deati To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	niner: On the best on and manner sta	examination an	e, death occu nd/or investig	rred at the timation, in my op	ne, date and pointion, death	place, and occurred a	due to the d	cause(s) a date and	and manner a place, and du	is stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		-		29c. License				29d. Date	signed (Mon	nth, Day, Year)
			17.	heller			D269	07			JAN	WARY	20,2006
5	AVA		30. Name and address of person who	completed cause of de	eath (ftem 23a)	(Type, Print)	Cuma Or	RLAND	MN				9
	Sta	į ate	31. Date filed (Month, Day, Year)		r's Signature	RUMU_	CUITIBE	KHILL	עוון)UL		
	Regist		JAN 2 3 2	006	· M	Lagar							

			For State Registrar	State of M	laryland		artment of tificate o			,	jiene	06	0361	5
	Physici	an	Decedent's Name (First, Midd	dle, Last)						Date of Dea Month	Day	Yea	3. Time of	
	/Medic		Owen	Hezekiah		Tu	cker			January	19	2006	8:00	a ^M
0	Examin	er	4a. Facility Name (If not institution				4b. City, Town	n, or Location	of Death		4c. C	County of De	eath	
			Anne Arundel					polis	- 041/				rundel	
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. la: 79	st birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day Feb • 22	Year)	1 .	Birthplace (State or Country)	r Foreign
	Director		578-22-9598 Usual Residence of Decedent		13	110.				Feb. 22	, 19	20 M	aryland	
	ow ow		10a. State 10b. Count	у	10c. City,	Town or Lo	cation						10d. Inside Cit	y Limits
	Mary fied	to	MD Anne	Arundel	Ede	ewateı	r						1 Tyes	2 XX No
	r 28s	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citize	en of What	Country?	
	h wit	a D	818 Selby Heig	ghts Drive			2	1037			U	SA		
	deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	. 13. \	Was Decedent of	of Hispanic O	rigin? (Spe	cify Yes or No- Rican, etc.)	14		merican Indian,	
ထ္	after or Ite	Fu	1 Never Married XX Ma	rried XXYes 2] No		res, specily c			nican, etc.)		Black, W	White	
2-0036	be filed within 72 hours after death with the Maryland tall Hygiene. do other than "natural", or items 23e or 28e-f show svent, the Medical Exerting rules for codified at	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or Dates	: 1944-4	46	100 100	10 3,000,00	··			рөспу.	WIIICC	
2	natu	Completed	15. Decede (Specify only high	nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do	ne during mo	st of worki	ng	16b. Kind	d of Busine:	ss/Industry	
2121	within ne. hen	m	Elementary/Secondary (0-12)	College (1-4or			DO NOT use rei ce Mecha	ŕ			A = 1 = 0	Com 1 # .	** *	l d'amac
N	filed v Hygie other t		9 17. Father's Name (First, Middle	/ 2st)	1	servic	e Mecha		nar's Name	(First, Middle,			tion/Appl	Liance
Maryland	ould be f Mental H arked of	Be	John Edward Tu						a Win		Maluen 3	umame)		
Ž	s 1 and 2 should be f Health and Mental ltam 27 is marked other traumatic sv	P P	19a. Informant's Name/Relation			10b Mailin	na Addraes (Str			I Route Numbe	r City or	Toum State	Zin Code)	
<u>M</u>	ロモトコ		Ruby M. Tucker				-			e, Edge				
	1 and 1 Health tam 27 other tr		20a. Method of Disposition	(WIIC)	20b. Pla		sition (Name of natory or other)			ate			or Town, State	
altimore,	permit. Pages 1 and Department of Healinportant: if Itam 2 any Injury or other 2002.		1 Burial 2 □ Cremation		8			1	1 0/	0006		·		
	it. P.		4 □ Donation 5 □ Other (21. Signature of Funeral Service		Mary	-	Vet. Ce		1-24-	2006	Chel	tenhai	m, MD	
Ba	Depa Depa Impo any I		17 7.1	he		22	Hardest	ty Fun	eral	Home, P	.A.			
3,			23a. Part1. Enter the disease,	or complications that cause	ed the death	Do not ente				, Annap		, MD	21401 Approximate	
4			shock, or heart failure. Lis Immediate Cause (Final	st only one cause on each	line.	20 1101 3111		1		. roopiiatory ari	031,		Interval Betw Onset and D	veen
	Pnysician /Medical	9 1	disease or condition resulting in death)	a. In		Van)-,(THOS	(1)				12 m	>
	Examiner			Due to (or a	s a conseque	ince of):	and the same						/	
(A) -		6	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a conseque	nce of):	70						year	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	<	1	,							/	
	end al-tra	xai	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	nce of):								
760,	ate be executed hysicien end the burial-transit	cai												
89	tificati ig phy as the			0.										
Вох	ndir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-				23	Bd. Date of o	delivery	
m	death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pregna] Other (s <i>pecify</i> ,					Month	Day Y	'ear
0	by the a	hys	9 □Unknown	9□ Unknown										
ري. ص	The law requires that the ate has been signed by the page 2 should be detache	by P	Part II. Other significant condit	tions contributing to death	but not result	ing in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco us	e contribute	to the cause of de	eath?
ğ	w require been sig should b									1 🗆 Y	es 2	No 3	DeBbably 4 □U	nknown
Records,	s bee	Completed								24a. Was a		24b. Were	autopsy findings a	ıvaılable
Re	The fa	mo								autops		prior t death 1 🔲 Y	to completion of ca ? 'es 2 26	use of
Vital		a	25. Was case referred to medic	al				26. Plac	e of Death	☐ Yes Check only or	-	161	95 2 740	
	Z .= 0	To B	examiner?	Hospital: 1 1 pat	tient 2 El	R/Outpatien	t 3 DOA			ne 5 ☐ Resid		□Other (S	pecify)	
Division of	ding Ph After th funeral		27. Manner of D oth	28a. Date of Inj	jury 2	8b. Time of	28c. lr	njury at Work?		28d. Describe h				
Ö	ittending death. ctor: After f the funer	ertification;	2 (3 . 100.1201.11	tigation	ay , oa.,	,a.y		Yes 2]No					
<u>N</u>	er de recto	tific	3 Suicide 6 Could 4 Homicide deter	mined 289. Place of Ir	njury - At hometc. (Specify)	e, farm, str	eet, factory, office	сө	- 1	28f. Location (S City or Tow	treet and	Number or	Rural Route Numb	⊃ <i>⊕1</i> ,
ā	tel or rs afte el Dir ed in	Cer			(-,,,						,,			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certify	ing Physician: To tre bes	t of my knowl	edge, death	occurred at the	e time, date a	and place, a	and due to the c	ause(s) a	nd manner	as stated.	
	To the H within 24 To the F complete	Medical	Orie)	and manner s	stated.					o at the time, u	iate and p	nace, and d		
	To To	2	29b. Signature and tyle of certific	ier //				ense number		5 ()	9d. Daje	signed (Ma	onth, Day, Year)	
			MI	161			07	1135	77	7	///	7/20	006	
			30. Name and address of person	V 1	death (Item)	За) (Туре,	Print)	1	00	y Ure-	0. 1	1c.	Los	
			Steron	Resul	_/-	NW	E /+	7 cm	les	ville	101	Lei	200	
	Sta	-0.0	31. Date filed (Month, Day, Yea		trar's Signatu	re	ach s							
1	Registr	ar //-	JAN 2 3	2006	W 10	14								

			For State Registrar	State of Marylar		partment of F prtificate of		, ,	201	06	03616
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Van	3. Time of Death
2	Physicia /Medic		Ruth Elizabeth Ums	stetter					9 20	06	1150 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. County	of Death	
	Funeral	<i>j</i> .e.t.	Peninsula Regional Med 5. Social Security Number 6. Sec		last birthda	y) If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		078-34-0655	1 ^M 2 ⊠ F 63	Yrs.	Months Days	Hours Mir	August	7,1942	New New	York
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or	Location				1	0d. Inside City Limits
	Mary a-f sho	tor	Maryland Wicomico	Sa	lisbur	. Y					1 ☐ Yes 2 🛣 No
	ith the or 28s	Directo	10e. Street and Number	*		10f. Zip Code		1	0g. Citizen of V	Vhat Cour	ntry?
	e 23e		27968 White Pond		10 140	21801	0	Canada Van an Na	USA 14 Peo		an Indian
36	72 hours after death with the Maryland *natural', or iteme 23e or 28e-f ehow Notal Exprinter man be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	7.5.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Pue	rto Rican, etc.)		e - Americ ck, White, :: Whi	etc.
2-0036	72 hou	eted	15. Decedent's Edu (Specify only highest grad		16a. Dec	cedent's Usual Occup	ation during most of w	orkina	16b. Kind of Bu		
21	be filed within 72 ho ital Hygiene. id other then "natures svent, the Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done . DO NOT use retired Lail Sales		J. Mary	Sears		
2	filed v Hygie other t	CO	12 17. Father's Name (First, Middle, Last)		1/6	Lair Dares		ame (First, Middle,		10)	
an		To Be	Willie Rucker				Josephi	ine Chris	t		
Maryland 21	and and is m		19a. Informant's Name/Relationship (Ty			iling Address (Street					Code)
	1 an Heal Heal Heal ther		Joseph Umstetter/Hi			8 White Poposition (Name of	ond Dr.	Date	20c. Location -		own State
altimore,	Se of or	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Ma	ryland metery	d Veterans	(9)	25/06	Hurlock		
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lizens			y 22. Name and Addre Holloway F 501 Snow H	ss of Facility uneral I	Home P.A.			
Г			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dee						Idia	Approximate Interval Between
) w	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to for as a consec	Cauence of):	Breast	64	ncer			Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury	Due to (or as a consec	quence of):						
<u>,</u>	execut n and ial-trar	Exan	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
68760	ficate be executed physician and is the burial-transit	edicai		i							
_	= 0.0		IF FEMALE:	20 If you outcome of group	a no.,					1	
P.O. Box	The law requires that the death certifi ste has been signed by the attending sege 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	BEctopic pregnancy Control of Con			23d. Dai Mo	te of delive	Day Year
	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions con	ntnbuting to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use ont	ribute to th	ne cause of death?
g	w require been sig should b							1 🗆 Y	es 2 d No	3 ☐ Prob	ably 4 □Unknown
Division of Vital Records,	The law rate has be pege 2 sh	Completed						24a. Was a autops perform	med2	Were auto prior to con death?	psy findings available inpletion of cause of
Vita Vita	nysicism: Th nis certificate i director, peg	Be	25. Was case referred to medical examiner?	lospital:		ont 3 DOA Oth	00	eath (Check only or			
ō	S S T	.T	1 Yes 2 No	28a. Date of Injury	ER/Outpati 28b. Time	of 28c. Injur	y at	Home 5 Resid			/)
Ö	ttending Phy death. stor: After thi the funeral	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2⊡No				
Divis	ei or Attens s after deat il Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm,	street, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospitei or At within 24 hours after d To the Funeral Direct completely filled in by	edicai (29a. Certifier 1 Certifying Phyone) 2 Medical Exami	sician: To the best of my knoner: On the basis of examination and manner stated.	ation and/or	investigation, in my o	pinion, death occ	curred at the time, d	ate and place.	inner as st and due to	ated. the cause(s)
	To the To the comp	ž	29b. Signature and title of pertifier			29c. Licens	e number	20	9d. Date signe	d (Month,	Day, Year)
)	(an			n.D.		Do	70 54/2	4		125	0/06
	50		30. Name and address of person who con Alow Davis m.	ompleted cause of death (Itel	m 23a) (Typ <i>10/ 5</i> /	4. Print) 	IsbUM.	MO 211	04		
100	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign.	ature	29c. Licens 29c. Licens 29c. Aprint) 34 34 34 34 34 34 34 34 34 3					
	Registr	ar .	JAN 2 4 21	JUO MARLES	KI. A	ADDAR!					

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F		and M		giene No. No.	06	03617
	Physicia	an	Decedent's Name (First, Middle,						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	BLANCHE ARLINE		harl	4b. City, Town, or	r I continu	of Dooth	January		2006 nty of Death	4:35 p M
	Examin	er	4a. Facility Name (If not institution, g Calvert County			Prince			k		vert	
	Funeral			. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under		8. Date of Birth (Month, Da)		9. Birth	place (State or Foreign intry)
	Director		577-14-7098	1□M 2\\ F	86 Yrs.	MORRIS Days	Hours	MIII.	May 8,	1919		yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	Mary 1 she lied a	tor	Maryland Calver	+	Prince Fr	ederick						1 X Yes 2 ☐ No
	th the	irec	10e. Street and Number	<u> </u>	Trance 11	10f. Zip Code				10g. Citizen o	of What Cou	untry?
	ath will	Funeral Director	195 Terrace Dr	ive		20678				U.S.A.	•	
	er des Items	nuei	11. Marital Status	Armed Ford	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori in, Mexican	gin? (Spa n, Puerto	ecify Yes or No- Rican, etc.)	14. R	lace - Amer lack, White	ican Indian, , etc.
39	irs aft	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	es:	1 ☐ Yes 2 🖾 No	Specify:			Spec	cify: W	hite
Ö	72 hours after death with the Maryland natural, or items 23a or 28e-f show deal Examinat must be notified at	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	t of work	ina	16b. Kind of	Business/li	ndustry
7	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4	4or 5+)	kind of work done of DO NOT use retired	d)	or work	9			
7	iled w Hygie ther tl		12 17. Father's Name (First, Middle, La	st)	Hous	ewife	18. Mothe	ar's Name	e (First, Middle,	Own I		
Maryland 21215-0036	ld be ental kad o	ТоВе	Delis C. Alfor						e M. Pi		,	
ary	shou and M s mar	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street					m, State, Zi	ip Code)
Σ	and 2 salth a n 27 i		Judith M. Roed	iger - Dau			Court					land 20622
ore	ges 1 t of Hi if iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from S	ate	matory or other plac			Date	20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marual Hygiene. Department of Health and Marual Hygiene. Informatic of items 23a or 28e-f show finortant: Items 23a or 28e-f show any injury or other traumatic evant, the Medical Examinar must be notified at once.		'4 ☐ Donation 5 ☐ Other (Special Service Lie		Parklawn Me							Maryland
Ba	permi Depa Impo any ir once.		21. Signature Structure Line	to the	1 1 1 1 1 1 1	2. Name and Addres 739 Balti					-	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that car	used the death. Do not en						, 110	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-	6 • •	trrby.	Hm	21/1				Onset and Death
	/Medical		resulting in death)		r as a consequence of).							
	Examiner	-	Sequentially list conditions.	b. Ath	ero Scle	rotic 1	arc	(10	Vascu	lan a	12eas	Q
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0) 01 800 (0	as a consequence or).							
Ć	execunand in and ial-tra	Еха	that initiated events resulting in death) Last	c Due to (o	r as a consequence of):							
8760,	death certificate be executed e attending physician and od for use as the burial-transit	ical	4	d								
39 ×	ertifica ding pt	Physician/Medical	IF FEMALE:	22a If year system	ama of aronnon.							
Вох	eath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir		Ectopic pregnancy Other (specify)	,				Date of deliv Month	very Day Year
P.O.		hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknov								
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to dea	th but not resulting in the u					bacco use co	ontribute to	the cause of death?
ord	v requires been sign should be	ted	Dianetes	mellit	15, Hypen-		Hecent			es 2□No	3 🗌 Pro	bably 4 donknown
	The ate h page	Completed	Kenal insu	Bhicie	ney, co	slon o	Cano	en.	perfor	sv	prior to co death?	opsy findings available ompletion of cause of 2 No
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		_	n (Check only or			
ō	Physic runis	: To	1 Tes 2 No 27. Manngrof Death	1 ∐ In 28a. Date of (Month	patient 2 ER/Outpatie	IL 3 DOA	4 💽 190	7	me 5 Resid			ify)
ion	Attending F r death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investiga		, Day Year) Injury		k? Yes 2 □ l	No				
Divis	i Sign	Certification:	3 Suicide 6 Could no determin	200. Place C	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office			28f. Location (S City or Tow		mber or Rui	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 ** Certifying (Check only one)	Physician: To the bastaminer: On the bastand manner	pest of my knowledge, deal sis of examination and/or in or stated.	h occurred at the tir vestigation, in my o	ne, date an pinion, dea	d place, th occurr	and due to the dred at the time, of	ause(s) and tate and plac	manner as e, and due	stated. to the cause(s)
	To the Complete	Ž	29b. Signature and the of certifier	C -	6 000	29c. Licens			26	29d. Date sig		, Day, Year) 2006
1	2		20 Name and address (no completed com-	of death (Item 222) (Time		500					2006
_(2		30. Name and address of person with the state of the stat	no completed cause eale	Church +		ANOOD		- SUI Dea		MD	20751
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signature	this						
	Registr	di	2.2. 200		- 7-							

		For State Registrar	State of Ma	aryland /		artment rtificate					giene Reg. No.	Hillin	036	18
Physic /Medi		Decedent's Name (First, Middle,	Last) Tony	Varro	on					2. Date of De Month Januar		, 2006	3. Time of I	
Exami		4a. Facility Name (If not institution, Larkin Chase Nu	ursing Home				Вс	Location o			4c. P	County of De rince	^{ath} George's	
Funeral Director		5. Social Security Number 579-03-8219 Usual Residence of Decedent	7. Age 11⊠ M 2□ F	9 (In yrs. last b	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da May 4,	y, Year)	8 Pe	irthplace (State or Country) nnsylvan	Foreign ia
Maryland -f ahow ied at	tor	10a. State 10b. County	e George's	10c. City, To	wn or Lo	cation	R	iverd	ale				10d. Inside City 1X Yes	•
with the 3a or 28a st te nati	I Director	10e. Street and Number 6802 Emerson	Street			10f. Zip		737			10g. Citi	zen of What (,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f ahow may injury or other traumatic evant. Ire Modical Evantical contined at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? d 1 Yes 2 N If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, Wh	nerican Indian, nite, etc. White	
d within 72 hc giene. Ir then "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			a. Deced (Give life. I	dent's Usua kind of wor DO NOT us Ba	l Occupa k done d e retired, ker	ition luring mos)	t of worki	ng		nd of Busines Privat		
yianta buld be file Mental Hyg arked otha atic evant,	To Be C	17. Father's Name (First, Middle, L Angelo Var							Mar	(First, Middle, Y Rosam	illi	a		
and 2 sho ealth and m 27 Is m		19a. Informant's Name/Relationshi	p (Type, Print) (Daughter)		1010	5 Mar	guer		Avent	JRoute Number Je, Gle	n Da	le, MD	20769	
Pages 1 tment of H tant: If ital		20a. Method of Disposition 1 □ Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp.	ecify)	20b. Place cemet Cedar	ery, cren Hil	natory or of .1 Cem	ther place neter	y 1,	/27/2		Su	itland	or Town, State	
Dermit Depart Import any in		21. Signaturo of Juneral Service L	Tent	2	- [9013	Аша	polis	s Roa	idon/Hai id, Lanl	nam 1		06	
Physician /Medical	_	23a P r1. Enter the disease, or shock, or heart falura in of of immediate Cause (Final disease or condition resulting in death)	a	inc	KB	er the mode		g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betw Onset and D	reen
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Hull b	a consequence	a of):	01:	धाम	Lw 8	CLO	WITC	W	ON-T	1011	RS
cate be executed physician and the burial-transit	Ical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as	consequence	e of):	ER.	C 51	5					1049	`S
ath certifi	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pre					2	3d. Date of d Month		ear
uires that the de signed by the a	by P	Part II. Other significant condition	s contributing to death but	ut not resulting	in the ur	nderlying ca	ause give	n in Part I			obacco u res 2[to the cause of de	
	Completed											prior to death?	autopsy findings at p completion of cares	vailable use of
To the Hospital or Attending Physician: Nuthin 24 hours after death. To the Funeral Director: After this certification of the funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 6 27. Manner of Death 1 Matural 5 Pending	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/C	Outpatien Time of	-	A Othe 8c. Injury Work	4 [] No	rsing Hor	(Check only one 5 Residence Residenc	dence 6		ecify)	
l or Attendir after death. Diractor: Af I in by the fur	Certification:	1 Matural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be as Slean of Init	ıry - At home,		М	1 🗆 1	fes 2□	-	28f. Location (S City or Tox			Rural Route Numb	ΘΓ,
Fo the Hospital or Attendi Within 24 hours after death. To tha Funaral Diractor: A	edical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination a	ge, death and/or inv	n occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the e	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)	
To th To th Comp	Me	29b. Signature and title of certifier	(vary	las	`	29c.	License	number	16.	_	29d. Date	e signed (Mar	nth, Day, Year)	
Se		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Type,	Print)	Tivn -	- 80V	ONA	Pi) . \	and miles	a lin	
St Regist	ate rar	JAN 2 6 2006	Seem 32. Registra	r's Signature	الم								V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item: 5 State of Maryland Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 5:05 PM al lace Tan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Road CORNER VO OV Talbot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number **Funeral** 10 M 2□F Min. 230-8898 Months Days Hours Usual Residence of Decedent Director Aug. Mary 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 77 is marked other then "natural", or items 23s or 28s-f show treumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director ordova Talbot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 439 2 6 CORNER Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 12 No Baltimore, Maryland 21215-0036 Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Repairman avvn-Mower 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental Wallace Mable Washington ISaac 19b. Mailing Address (Street and Number or Rural Route Number, City or own, State, Zip Code) 19a. Informant's Name/Relationship (Type, Kitty's CORNER Rd, COY dova MD, 2

Name of Date 20c. Location - City of Town, State MD,21625 Department of Health a Importent: If item 27 is any injury or other tre once. Wallace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □ Removal from State 128/06 Cordova, MD Cemetery hapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Here Ry Fune Ra / Home, P. A.
510 Washington St. Cambridge, MD. 2161
Approximate 21. Signature of Funeral Service Licensee anell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RENAL DISEASE STAGE Immediate Cause (Final END **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown cate has been signage 2 should b Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 Yes 25 Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 1 ☐ Yes 2x No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specily) this 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral E completely filled it 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057067 wal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMIAN SOOKLAL , 607 DUTCHMANS LANE, EASTON MD 21601 32. Registrar's Signature 2006 State Registrar

		ľ	State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Mental Hy rtificate of Death	giene 006	03620
			Decedent's Name (First, Middle, Last)	2. Date of De Month	path Day Year	3. Time of Death
	Physicia /Medic		Mary Madeline Waters	Januar		6:49pm M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat	
			Geneisis Magnolia Center	Lanham If Under 1 Year If Under 24 Hrs. 8, Date of Bir	Prince Ge	
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 226-42-2784 1□ M 2☑F 88 Yrs.	Months Days Hours Min. (Month, Da	ay, Year) 9. Bin L4, 1917 Mai	hplace (State or Foreign ountry)
			Usual Residence of Decedent	bept.	.4, 1717 Hal	yıanı
	how		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e Ma 3a-f s	cto	Maryland Prince George Forestvi			1 No 2 No
	vith th	Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	
	s 23s	rai	2100 Brooks Drive, Apt. 304 11 Marital Status 12 Was Decedent Ever in U.S. 13.	20747	United St	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I're Madical Examination and illied at an	by Funerai	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 ☐ Yes 2払 No Specify:	Black, Whit	e, etc.
Ö	72 hou		15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b. Kind of Business/	/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		
2	filed w Hygier other th	ပိ	17. Father's Name (First, Middle, Last)	ge Attendant 18. Mother's Name (First, Middle	Privat	е
Maryland 21215-0036	d be fi	To Be	George Young	Pearl Holly	, walden Sumame)	
ary	should be ind Mental marked o	F	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route Numb	er, City or Town, State, a	Zip Code)
ž	alth a		Christine Waters/Daughter 2100	Brooks Drive #304; Fores	tville, MD.	20747
timore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of Date matory or other place)	20c. Location - City or	Town, State
Ĕ	Pages ment of I ant: If ite ury or o		`4 □Donation 5 □Other (Specify) Mt. Olive	t Cemetery 02/01/06		, D.C.
Balt	permit. Page Department of Important: If any injury or once.			2. Name and Address of Facility 5538 Mar pe Funeral Homes Forestvi	lboro Pike lle, MD. 20	0747
	- 11		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory a	rrest,	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	tion Pneumonia		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		20	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
П	ted tusit	mine	Cause (Disease or injury			
o Î	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai Examiner	that initiated events resulting in death) Last			
8760,	ate be nyskia he bur	Icai	d			
ဖ	ing ph	Med	IF FEMALE:			
Вох	that the death certifice ed by the attending ph detached for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of del Month	livery Day Year
0	he de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		
۵.	res that ti igned by be detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23e. Did	tobacco use contribute to	the cause of death?
ds	puires n sign ald be	q p	Dysphagia, Sebsis	1 🗆	Yes 2 No 3 Pr	obably 4 Unknown
00	tw require s been si should b	Completed	Cerpovascular Acc	ideul- 24a. Was	an 24b. Were at	topsy findings available
Be	The la te has	omp		auto	ormed? death?	completion of cause of
Ita	ian: rtifica	Bec	25. Was case referred to medical	26. Place of Death (Check only		
<u></u>	hysic his ce I direc	2	examiner? 1 ☐ Yes 2 ☒ No			cify)
0	Attending Physician: ir death. ector: After this certifics by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	how injury occurred	
<u>s</u>	or Attending after death. Director: After in by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	Street and Number or Ru	ural Route Number
Division of Vital Records,	after of Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or To		arai riodio rvambor,
_	To the Hospital or Attending Physician: The lav Mithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat			
	he Ho in 24 I he Fu pletely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	comple	Σ	29b. Signature and title or contiler	29c. License number	29d. Date signed (Mont	
(40)00		I COUG ITD	D 48213	January 26	, 2006
	A CONTRACTOR OF THE PROPERTY O		30. Name and address of person who completed cause of death (Item 23a) (Type, Neelam Ashai, M.D 4410 74th Avenue;		84	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2006 32. Registrar's Signature			

		•	For State Registrar	State	of Marylar		artment of H tificate of I			gieņe _{Reg. No.} ()	06	0362	CCUP Deadle
		24	1. Decedent's Name (First, Middle	Last)					2. Date of De.	ath Day	Year	3. Time of De	eath
	Physici		George Kenneth	William	S				January	o i	2006	9:55 AN	1 M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of Deat			unty of Deat	th	
	2,0,1111	٠.	Wicomico Nurs	ing Home			Salisb	urv		Wic	omico		
	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird	th v. Year)	9. Birt	thplace (State or Fountry)	oreign
D	Director		215-14-3575	1 ₫ M 2□F	85	Yrs.	Worldis	10010	April 1	(7,192)) Mar	cyland	
	P.		Usual Residence of Decedent		40- 0	. T	4:					10d. Inside City	Limita
	show	_	10a. State 10b. County			ty, Town or Lo	cation					1. Yes 2	
	e Mar-f	cto	Maryland Wicomi	CO	Sal	isbury							
	or 24	Director	10e. Street and Number				10f. Zip Code			•	of What Co	ountry?	
	23a	ra E	900 Booth Stree			1	21801			USA			
	tams	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or No to Rican, etc.)	- 14.	Black, White	erican Indian, e, etc.	
36	or i	by Fi	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	If Yes. G	2 XNo		1 □ Yes 2 🕱 No	Specify:		Sp	ecity:	√hite	
0	filed within 72 hours after death with the Maryland Hyglene. thar than "naturat", or itams 23a or 28a-f show thar than "naturat", or itams 2an be indiffied at int, the Medical Exeminar must be indiffied at	d b	15. Decedent	Year or	Dates.	16a Dece	dent's Usual Occup	eation		16h Kind	of Business/		
21215-0036	"naf	Completed	(Specify only highes	grade completed	")	(Give	kind of work done	during most of wo	rking	TOD. IXING	J. D 45111053	industry	
7	withii ane. than	mc	Elementary/Secondary (0-12)	College	(1-4or 5+)	Carper				Home	Improv	zement.	
2	filled Hygi thar	ပ္	17. Father's Name (First, Middle, I	_ast)		-carpe.		18. Mother's Na	me (First, Middle,				
Maryland	d be antal ced o	o Be	Samuel Williams	,				Annie J	ohnson W	Jillia:	ms		
2	shoul od Me mark mati	은	19a, Informant's Name/Relationsh			19b. Mailir	ng Address (Street					Zip Code)	
Z Z	id 2 strau		Kim Ward/ Grand	l-Daughte	r	113 N	Middleton	Place M	ooresvil	le, N	orth (Carolina	2811
Ġ,	1 an Heal tam 2		20a. Method of Disposition			_	sition (Name of natory or other place		Date		ion - City or		
õ	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State				100	II - b	- M	المسم أحسم	
Baltimore,	it. Purtme	-	21 Cign: In a large State (St	ecny)			emetery L. Name and Addre	1/29	A Section of the Control of the Cont		n, Mar	ryland	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is merked othar than "naturat; or itams 23a or 28a-f show any figury or other traumatic avant, the Medical Examinat must be multibut at Once.		CD CO	10	CF	SP HO	Name and Addre Olloway F Ol Snow H	uneral H	ome P.A.	No.	rul and	NORIC F	10
į.			23a. Part1. Enter the disease, or	complications that	caused the dea						Lyranc	Approximate	
	+ +	8	shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.				200			Interval Betwe Onset and De	
2	Physician /Medical		disease or condition resulting in death)		O (or as a conse		ARDIOVA	SCULUR	VISE	15E_			
Ü	Examiner			Due (c	O (OI as a conse	quence or).							
L		er	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a conse	quence of):							
	ted nsit	- L	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to	o (or as a conse	quence of):							
58760,	icate be executed physician and s the burial-transit	la:		d									
687		edical											
Xo	eath certif attending for use a:	N/	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		7-			230	i. Date of del	livery	
ă	death cer attendin	Physician/M	in the past 12 months?		birth 2 ☐ Fet gnant at time of]Ectopic pregnancy] Other (s <i>pecify)</i>	y 			Month	Day Ye	ar "
o.	at the de by the a tached	nysi	9 Unknown	9□ Unk	nown								
0	law requires that the death certif as been signed by the attending 2 should be detached for use a:		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of dea	ith?
ds	puires n sign	d b	HYPELTENSIAN	<i>'</i>					1 🗆	Yes 2□N	lo 3□Pr	robably 4 Uni	known
CO	w requir been si should	lete	PARLIAKONE	DISCA	-				24a. Was		4b. Were a	utopsy findings av	ailable
Records,	The lay ate has page 2	Completed by	A						auto	psy ormed? 2 X No	prior to death? 1 \(\sum \text{Yes}	completion of cau	se of
a	n: T flicate or, pa	e Cc	25. Was case referred to medical	V IS	EASE			26 Place of De	1 ☐ Yes ath (Check only of		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 2A NO	
Vital	Physician: The la r this certificate ha ral director, page 2	00	examiner?	Hospital:	Inpatient 2	TER/Outnatier	nt 3 DOA Oth	E-340	Home 5 Resi		Other (Spe	ecify)	
of	Phy r this sral d	. To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o	f 28c. Injur	ry at	28d. Describe			,)	
on	ding th: Afte	101	1 Natural 5 Pendin 2 Accident investig	9	onth, Day Year)	Injury	Wo: M 1 □	rk? Yes 2 □ No					
Division	Attanding r death. actor: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could r	ined 200. Plat			reet, factory, office				lumber or R	ural Route Numbe	er,
ā	after after Dire	ert	4 Homicide	buil	ding, etc. (Spec	iry)			City or To	WII, SIAIE)			
	Hospital 24 hours a 5unaral l tely filled	a C	29a. Certifier Certifyin	g Physician: To t	ne best of my kn	owledge, deat	h occurred at the ti	me, date and plac	e, and due to the	cause(s) an	d manner as	s stated.	
	ha Hospital or Attanding Phys n 24 hours after death. ha Funaral Diractor: Atter this pletely filled in by the funeral di	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examin inner stated.	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and pl	ace, and due	e to the cause(s)	
	To the Hospital or Attan within 24 hours after deat To the Funaral Director: completely filled in by the	Me	29b. Signature 200 title of certifier				29c. Licens	se number		29d. Date s	igned (Mont	th, Day, Year)	
	,- ,- ,- 0		Maharet	11/11	1	1M	D-1	20/001	5	1/	24/1	6	
	2111		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	J 6-31.		1	1	0	
	1001		Maesha Thimm	aravanna			ternshore	e Dr Sali	isburv M	D 2180)4		
	Sta	ite	31. Date filed (Month, Pay Year)	6 2000 32.	Registrar's Sign	ature	1/			11			
151	Regist		JANZ	6 2006	STARLS.	13.	Soll .						

DHMH 17 Rev 1/2001

George Williams

		ľ	1 - State Registrar	State of Marylan		nt of Health and l	Mental Hygier	4000	03622
4	Yorker stay		1. Decedent's Name (First, Middle, Last		1 .		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		+RANCE.	5 HNN W	escott		lancear	112006	1139 M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Deat		c. County of Death	
4	¥	· 6.	Peninsula Region 5. Social Security Number 6. Se	7///	Conta	er 1 Year If Under 24 Hrs	9 Date of Righ		
	Funeral: Director			M 200 F 52	Yrs. Month:			3	nplace (State or Foreign
.4			Usual Residence of Decedent	0.00			0/3/0		
	how	_	10a. State 10b. County		y, Town or Location		, ,		10d. Inside City Limits
	Ba-f	Director	MD WICOM	1100 5	Alisbui	7			1 Yes 2 No
	with th	Dire	10e. Street and Number	- n + ah	10f. 2	ip Code	10g. (Citizen of What Co	intry?
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funeral	702 1 Aylon 57	12. Was Decedent Ever in U.	.S. 13. Was Dec	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	ican Indian,
	riter d	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, sp	ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	, etc.
003	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: B	ACK
ر ا	I within 72 hours after death with the Marylar jiene. Jiene. The "natural", or lienns 23a or 28a-1 show the Medical Examinating at the notified at	Completed	15. Decedent's Edi (Specify only highest grad		16a. Decedent's Us (Give kind of y	ork done during most of wo	rking 16b.	Kind of Business/I	ndustry
2	within ane. then	m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT		12 C	(2/2)	+. STORE
2	be filed ital Hygie d other event, I	e Co	17. Father's Name (First, Middle, Last)		KNUIROM		me (First, Middle, Maid	en Sumame)	1.3.000
Ian	lid be lental rked c	To Be		Floyd W	estott	Acho	UA Fito	hett	
ary	and N		19a. Informant's Name/Relationship (7	rpe, Print)	19b. Mailing Addre	ss (Street and Number or Ru	ural Route Number, City	or Town, State, Z	ip Code)
Σ.	s 1 and 2 of Heelth item 27 i		Shange ga Chels	stian. daughter	401 4m	+ Pocomok	e,MD 2	21851	
0	B 0 = 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Di	Removal from State	Place of Disposition (A cemetery, crematory of	other place)	Dare 20c.	Location - City or	Town, State
Saitimor	5 2 3		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		MATORY 01	and Address of Facility	97/06 D	EIMAIZ,	1)8
n	permit. Depert import eny in		X Mincella I	Dand)	- 8	Smith rungely	I toma	his ME	21801
	- R		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat	h. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,	Jury!	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Allegoschond	i Coronare	Och Die	20050		Onset and Death
	/Medical Examiner	ię.	resulting in death)	Due to (or as a conseq		0 1	A .	_	
	LAdillilici	_	Sequentially list conditions,	b. Due to (or as a conseq	structive	Pulmonary	Disease		
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice or).				
,	execu n and iai-tra	Examine	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):			:	
9/9	ate be executed hysicien and the burial-transit	dicai	(d					
٥	artifica ing ph e as th	Med	IF FEMALE:						
X OZ	death certific e ettending p od for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete	el death 3 Ectopic			23d. Date of deli Month	very Day Year
	he de r the e ched f	Physician/Med	1 Yes 2 No	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5 🗌 Other (specify)			
ř.	requires that the death certific een signed by the ettending p hould be detached for use as		Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds,	quires on sign	ed by					1 ☐ Yes	2 □ No 3 Pro	obably 4 Unknown
ecord	aw as b	Completed					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
I	The ete h page	Com					performed 1 ☐ Yes 2 💢	? death?	2 □ No
Vital	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Una-itali		0.1	ath (Check only one)		
6	Physi this o	. To	1 ☐ Yes 2 No 27. Magner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 1 1		dome 5 ☐ Residence		ify)
o	ding Ph h. After th funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? t ☐ Yes 2 ☐ No	200. 2000.100 11011 41	fully occurred	
Division	al or Attendi after death. I Director: A d in by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Street	and Number or Ru	ral Route Number,
ā	s afte	Certification:	4 Normade	Building, etc. (Specif			City or Town, St	110)	
	To the Hospitel or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certific, complejely filled in by the funeral director,	edical	(Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	othe ithin 2 o the ample	Med	one) 29b. Signature and title of certifier	and manner stated.	2	9c. License number	29d. [Date signed (Monti	n, Day, Year)
)	F3 F8) (h)	mn		IXUITA		1/18/0	
	B		30. Name and address of person who o		m 23a) (Type, Print)	237121		.11010	<u>/</u>
	iD		Alon DAVIS MC	100 Power	v St. S	salisbury	MD 218	04.	
	Sta		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ature				

			1 - For State Registrar	State of Ma	ryland /		tificate of				g. No.	03623
	Physici		1. Decedent's Name (First, Middle, La:		NIND	50	> ,			Date of Death Month	Day Year	
	/Medio		4a. Facility Name (If not institution, giv-	e street and number)	1 1/		4b. City, Town,		of Death		4c. County of Dea	ath
	tak .	16.		at the	Lafe		Salis		9		Wicon	
	uneral irector		210 22 3311	ex 7. Age ☐ M 2√ F	(In yrs. last	Yrs.	If Under 1 Year Months Days		Min. 01	Date of Birth	9. Bi	rthplace (State or Foreign ountry) ITICOKE, MD.
land	A H		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation					10d. Inside City Limits
Man	- a	tor	MD WICO	MICO	HEBR	ON						X□Yes 2□No
ith the	or 28	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of What C	*
eath w	10 23a	erai	104 TARA LANE	12. Was Decedent E	vos in II C	12 1	Von Doordook of I	2183		Y	14. Race - Am	
III	reportants if them 21 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Evantual must be inclined at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed	Armed Forces? 1 Yes 2V No If Yes, Give Year or Dates:		1	Vas Decedent of I Yes, specify Cub			n, etc.)	Specify: Wh	ite, etc.
2 P	natur	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16	6a. Deced	ent's Usual Occup kind of work done	pation during mos	st of working	1	6b. Kind of Business	s/Industry
Mithin 6	n Wa	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	·)	`life. [kind of work done OO NOT use retire AGENT	id)			INSURANCE	:
filed A	other ent, II		17. Father's Name (First, Middle, Last)	4			710211	18. Mothe	er's Name (Fir	st, Middle, M	laiden Sumame)	
uld be	rked tic ev	To Be	WILLIAM COX					BLA	ANCHE W	HITE		
2 should	is ma		19a. Informant's Name/Relationship (City or Town, State,	· ·
1 and	em 27 ther to		SUZANNE KYGER -D. 20a. Method of Disposition	AUGHTER					KUAV, S		LL, MARYLA Oc. Location - City o	
Pages	t: # ite		1 ☐ Burial 2 ☐ Cremation 3 ☐				sition (Name of patory or other pla				DELMAR, DE	
permit. P	ortan Injur		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fun (of Service Licer		CKEMA						RAL HOME,	
ă ă ă	any ir		1/16/1950 F	y Helly								AND 21804
	sician		23a. Part) Enter the disease, or only shock, or heart failure. List only Immediate Cause (Final disease or condition				_			spiratory arres	st,	Approximate Interval Between Onset and Death
	ledical aminer		resulting in death)	Due to (or as a	consequence	ce of):	CANO					11.0551
i de		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			aul of					I WEEK.
cuted	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
5 exe	cian a purial-t	I Ex	resulting in death) Last	Due to (or as a	consequenc	ce of):						
rificate be executed	ng physician and as the burial-transit	adica		d								
Centif	attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							23d. Date of de	alivery
Physician: The law requires that the death ce	he atte	sicia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			Ectopic pregnanc Other (specify) _	у			Month	Day Year
het the	signed by the a Id be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions c		not reculting	a ia the ue	darking agusa au	on in Dard I		22a Did tobe	2000 usa contributa t	o the cause of death?
uires t	signe Id be o	d by	Tatti. Ottor digitiroant donations o	onthouting to abath but	not resulting	9 111 (110 (31)	derlying cause gr	restration and i		1 🗆 Yes		robably 4 \(\sum \sum \sum \text{Unknown} \)
5 × ×	s peen s	Completed								24a. Was an		utopsy findings available
The la	ote has	duo:								autopsy perform 1 □ Yes 2	prior to	completion of cause of
cian:	certificete rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	e of Death Ch			20110
hysic	this co	၉	1 ☐ Yes 2 No	Hospital:			3LI DOA				ice 6 Other (Spe	ecify)
- 0	After this funeral di	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 280	. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2□		Describe hov	v injury occurred	
Atten	Director: After this certificate had be in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home,	farm, stre			28f. I	ocation (Stre	et and Number or R	lural Route Number,
Ital or	ial Dir	Cert	Totalde	building, etc.	(эрөспу)					City or Town,	State)	
the Hospital or Attanding	To the Funeral Director: A completely filled in by the to	edicai	29a. Certifier Certifying Ph	ysician: To the best of	examination a	lge, death and/or inv	occurred at the trestigation, in my	me, date an opinion, dea	nd place, and o th occurred at	due to the cau the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To the	го the			and manner state		-	29c. Licens	se number		29	d. Date signed (Mon	th, Day, Year)
r. s	63		Varen D	Equal	N	UT	> >>	142	56		1/22/0	6.
	· K		30. Name in address of person who some filed (Month, Day, Year)	completed cause of dea	ath (Item 23a	a) (Type, F	Print) COS	7712	Hos	PICE	ATC	AKE
Service a	5		31. Date filed (Month, Day, Year)	ISAAC 32. Radistrar	Signature	NE	ERSH	EX	> 5	ACISI	3 URY N	1D S/00/
Section of the section	Sta	re l	J. Date med (month, Day, 19al)	JZ. Figistial	- crymature		all a					

State

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland /	Depa Ce	artment of He rtificate of D	ealth and M Death		Co U U U	03624
	Physici	an	Decedent's Name (First, Middle,	Last)			timodio or E	- Odii i	2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	An Facility Many (15 and 1 and 1)		nder Wilso	n				ry 25, 2006	10:05 A ^M
	Examir	er	4a. Facility Name (If not institution,	16108 Buck's			4b. City, Town, or	Location of Death Lonace	onina	4c. County of Dear	
	Funeral				Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birt	llegany hplace (State or Foreign untry)
	Director		217-28-0220 Usual Residence of Decedent	1♥M 2□F	73	Yrs.			April 20,		Maryland
	nyiand thow		10a. State 10b. County		10c. City, To	own or Lo	ecation				10d. Inside City Limits
	he Ma 28a-f s	Director	ļ	Allegany				Lonaconing			1 (∑Yes 2 □ No
	3a or		10e. Street and Number	08 Buck's Hill			10f. Zip Code	21539	10g	. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exacting roual be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1	is? ₹No	1	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 1 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	rican Indian,
2-00	72 hou nature lical E		15. Decedent's	Education		Sa. Dece	dent's Usual Occupat	tion	. 16	b. Kind of Business/	White Industry
21215-0036	within 7	Completed	(Specify only highest Elementary/Segondary (0-12)	College (1-40	or 5+)	life.	kind of work done du DO NOT use retired)		ing		
d 2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, L					intenance 18. Mother's Name	e (First, Middle, Ma		g Home
/lan	Mental Mental arked	To Be	L	eonard David	Wilson				Ella	Beeman	
Maryland	12 sho h and 7 is ma rrauma	/ 1	19a. Informant's Name/Relationshi Jeanette (Fazenbak		/ife	9b. Mailír				City or Town, State, 2	
ē,	tem 2:		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of			Maryland, 215 c. Location - City or	
<u>ii</u>	Pages nent o ant: If ury or		1 🏿 Burial 2 🗋 Cremation : 3 4 □ Donation 5 □ Other (Spe		18		natory or other place. I Hill Cemeter	l Ja	anuary 28, 2005	Moscow Mil	ls Maryland
Baltimore,	permit. Departi Importi any inj		21. Signature of Funeral Service Li				. Name and Address Eichhorn-N	McKenzie Fu	uneal Home I	P.A., 8 East M	
			23a. Part1. Enter the disease, or connections, or heart failure. List o	omplications that caus	sed the death. D	o not ent	er the mode of dying,	Lonacor such as cardiac o	nng, Marylar or respiratory arrest	nd, 21539	Approximate Interval Between
Z	Physician /Medical	a b	Immediate Cause (Final disease or condition resulting in death)	a. CA	RDIAC		YsRhyt	hmia			Onset and Death 2 Hours
	Examiner	1		Due to (or a	as a consequenc	e of):	1				920
	p Æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or i	a ecnesquenc	s of):					
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a consequenc	e of):					
68760,	ificate be executed g physician and as the burial-transit	edicai E		d.		,-					
. 68	ertificat ing phy e as th		IF FEMALE:								
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	quires that en signed b uld be deta		Part II. Other significant condition	s contributing to death	Ry 0/	in the un	derlying cause given 456 710W	in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to	the cause of death?
Division of Vital Records,	The la	Completed	Released	locardial	- Inf	arc	TION		24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
Vita Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		(Check only one)		
ō	g Phys er this eral dii	٦. ا	1 ☐Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa 28a. Date of In (Month, D	tient 2 ☐ ER/C njury 28b	. Time of	28c. Injury a Work?	4 Nursing Hon	ne 5 Residence 28d. Describe how i	e 6 Other (Specinjury occurred	ify)
ion	ending sath. or: Aft he fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day Year)	Injury		s 2 🗆 No			
DIXI D	tel or Attending Phy s after death. al Director: After this ed in by the funeral d	Certification:	3 Suicide 6 Could no determin	ed 286. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, stre	eet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rui itate)	al Route Number,
	To the Hospitel or Attending Physicien: To the Funeral Director: After this certified completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis and manner	or examination a	ge, death ind/or inv	occurred at the time estigation, in my opir	, date and place, a nion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	1			29c. License r			Date signed (Month	Day, Year)
			20 Nome and add	angen	doub (the of	\	<u> </u>	638	CHANG.	annary S	25, 2-006
			30. Name and address of person with the Broad Wa	y Fr	stowy		rint) SATA	RNIOVA 21.5	32	THE Y.	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 2 6	2006 32. Regis	trar's Signature	Co	edis				

			1 - For State Registrar	State of	Marylan	-			and M	ental Hygi	-	03625
			Decedent's Name (First, Middle,	Last)						2. Date of Death		3. Time of Death
	Physici /Medio		Burl Lee	Welch						Month January	Day Ye	06 10:20 A ^M
	Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location	of Death	January	4c. County of	Death
			Garrett County					0 a kl				arrett
ľ	Funeral		,	5. Sex 7 1 M M 2 □ F	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
L	Director		212-34-5935 Usual Residence of Decedent	A -	76	113.				June 26,	1929 M	[aryland]
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-fel	ctor	MD Ga	rrett			Mount ai r	Lake	Park			1 √ Yes 2 □ No
	ifn fh)ire	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	t Country?
	afh w	Funeral Director	110 A Street, A					21550				SA
	er de Items	nue	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	irs aft	by F	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 If Yes, Give Year or Dat			1□Yes 2덨N	o Specify:			Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f ehow then "metural", or Items 28e or 28e-f ehow the Medical Examiner must be mailfurd at	ted	15. Decedent's		1		dent's Usual Occ			1	6b. Kind of Busin	ess/Industry
215	thin 7 e. en."n Med	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	for 5+)	(Give life.	kind of work don DO NOT use retii	e during mos ed)	t of workir	ng		
7	ed wi	Completed	8th				Ste	el Wor				struction
and	be fil ntal H od ott	Be	17. Father's Name (First, Middle, L.							(First, Middle, Ma		
ž	hould d Mer marke matic	2	Lester Roy 19a. Informant's Name/Relationshi		cn	10h Maili	- 4 (24		nanor			Johnson
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar then "netural", or Items 23e or 28a-f ehow eny injury or other treumatic event, Ite Medical Examiner must be multified at once.									/ Route Number,	eart 6.040h	
	s 1 and 2 of Health a item 27 is other treu		Alice Welch/wiff 20a. Method of Disposition	е	20b. P	ace of Dispo	sition (Name of		104 D	Mt. La	IKE Park, Dc. Location - City	
Baltimore,	Page: ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe		ate	_	natory or other pi metery		1/27	/2006	0-1-13	w.i
aĦ	mit. partm sorta / inju		21. Signature of Funeral Service Li	-	LASI		. Name and Add			A CONTRACTOR OF THE PROPERTY O	Oakland S. Sec	
m	permi Depa Impo eny ir		> Swellen H	Diner		S	tewart F	unera]	l Hom			4d. 21550
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can	used the death	. Do not ent	er the mode of dy	ing, such as	cardiac or			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a_Coron	ary Art	ery D	docao!					Onset and Death
	/Medical Examiner		resulting in death)		r as a consequ		LOURGE					years
	LAdiiiiiei	<u>.</u>	Sequentially list conditions,	ь. Diabe								years
	pet usif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	ience or):						
	al-trai	xar	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ience of):						
760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	call		d.								
89	tificat ng phy as fh	Physiclan/Medical	-	and a suite			1 /21/10/					= =====================================
Вох	leafh certific affending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar h 2 □Fetal		Ectopic pregnan	cv			23d. Date of	•
Э.	e dea he afi ied fo	sicl	in the past 12 months? 1 □ Yes 2 □ No		nt at time of de		Other (specify)				Month	Day Year
P. 0.	that the de led by the a detached t	Phy	9 Unknown			late of the				Didast.		
Š,	signed I	l by	Charat Manda T			iitirg in the ui	idenying cause g	iven in Part I.		239. Did (0ba		e to the cause of death? Probably 4 □Unknown
Š	w require been si should b	etec	Charot-Marie-T	ooth bise	ase					1		
Division of Vital Records,	ne lav s has ge 2 :	Completed								24a. Was an autopsy performe	l prior	e autopsy findings available to completion of cause of h?
ā		e Co	25. Was case referred to medical					00 71	-4 D45		10	Yes 2□No
>	yeicien: The is certificate ha director, page	0 B	examiner?	Hospital:	patient 2 🗆 E	ER/Outpatien	t 3 DOA	sh = -		(Check only one) ne 5 ☐ Residen	ne 6 □Other /	Procify)
ō	Attending Physicien: or death. sector: After this certifici by the funeral director.	T:U	27. Manner of Death	28a. Date of	-	28b. Time of	28c. Inju			8d. Describe how		эрөслуу
jo	ttendin death. ctor: Afr	atlo	Natural 5 Pending 2 Accident investiga	tion	buy rous)	injury		Yes 2 🗆	No			
Ž	r Atto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place o	f Injury - At hor , etc. (Specify,	me, farm, str	eet, factory, office)	2	8f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,
	urs af urs af arel D								- 71			
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	29a. Certifier Certifying (Check only one) 2 Medicel Ex	Physicien: To the b eminer: On the bas and manne	is of examinati	vledge, death ion and/or inv	occurred at the restigation, in my	time, date an opinion, dea	d place, a th occurre	nd due to the cau d at the time, date	se(s) and manne a and place, and	r as stated. due to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier		, statou.		29c. Licer	ise number		290	. Date signed (M	onth, Day, Year)
i	⊢ s ⊢ õ		> tolat	·	-		1)	153	33			1/06
	1		30. Name and address of person w	no completed cause	of death (Item	23а) (Туре,					116	,, ,,
_	4		Thomas Johnson	M.D. 311	N. Fou	rth S	., 0akl	and, M	ld. 2	1550		
	Sta	te	31. Date filed (Month, Day, Year) JAN 2 5		jistrar's Signat							
R	Registra											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Nellie Naomi Wagner 3:30 P.M. Jan 19, 2006 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Goodwill Mennonite Home Inc. Grantsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□ F Director 236-48-7644 Dec 31, 1908 W٧ Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mentel hygiene. Important: if Item 27 is marked other than "naturel; or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified at ence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director MD McHenry Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. Box 390 21541 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify <u>۾</u> White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dicie Nestor William A. Jefferys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Ringer P.O. Box 390 McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/22/06 Addison, PA 15411 Addison Cemetery 21. Signature F 22. Name and Address of Facility neral Sen Carl R. Spear Funeral Home RR 5, Box 1, Brandonville Hgts. Bruceton Mills, WV 26525 23a. Part 1. Enter the disease, or comshock, or heart failure. List only ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) MEUMONIA /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? RHEUMATOID ARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? s certificate has b 1LIYES 2LINU 1 ☐ Yes 2 ☑ No r: After this certificel e funerel director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending s efter deeth. I Director: After de in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled To the Hospital edical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number

State Registrar

29b. Signature and title of certifier

Dr. Robin Bissell,

31. Dete filed (Month, Day, Year) JAN 2 32. Registrar's Signature

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

124 Miller Street, Grantsville, MD

D0034231

CPM06-00615 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Watts, Jr. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 25, JOHN DONALD WATTS, JR. January 2006 01:56 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1943 27012 Bunny Lane Talbot 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral ™** M 2□ F NEW YORK 62 Yrs. Director 055-34-6133 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at EASTON 1 ☐ Yes 2X No by Funeral Director MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 Iteme 23a 27012 BUNNY LANE filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 Specify: WHITE 1 ☐ Yes X No 3 Widowed 4 Divorced "naturel". Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 ENGINEER BUSINESS permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 ie marked othe eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN D. WATTS JULIA ZOLLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE M. WATTS/WIFE 27012 BUNNY LANE, EASTON, MARYLAND 21601 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 1/26/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 Doseph m Cstrousk: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician COMTACT GUNSHUT MOUND /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical examiner? certifi Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA TX Yes 2 □ No this s after death.

I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of FORMD 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural SUBJECT Snow SEIF investigation 1:54 A М 1 ☐ Yes 2. No 125/06 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide of yard residence ON MOTERS US PHINE Front 27012 pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lymedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

within 24 hours a To the Funeral C

State Registrar

completely

31. Date filed (Month, Day, Year)

JAN 2 7 2006

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

and manner stated.



29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 25, 2006

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 5

	1	For State Registrar			ertificate of I	Death	F	Reg. No.	
Physician /Medical		Decedent's Name (First, Middle, La MYRTLE LEE YOUNG	ist)				2. Date of Dea Month	3 acol	
Examiner	4	a. Facility Name (If not institution, given the SALISBURY REHAB &		ENTER	SALISBURY			4c. County of Dea	
Funeral: Director		228-24-1937	Sex 7. Ag 1 ☐ M 2 ☐ XF	e (In yrs. last birthda 81 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12-05-1	9. Bir (, Year) 9. 24 V	thplace (State or Foreig buntry) IRGINIA
•how	-	Jsual Residence of Decedent 10a. Sfate 10b. County MD WICOM	T.CO	10c. City, Town or					10d. Inside City Limit
ms 23a or 28a-f show rinust be notified at nerai Director		I0e. Street and Number		BALISDU	10f. Zip Code	2100/		10g. Citizen of What C	
of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 ehow other traumatic event. The Medical Examinat must be notified at other traumatic event, the Medical Examination of the notified at To Be Completed by Funeral Director		905 PRESTON STRE	12. Was Decedent Armed Forces? 1		3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	21804 ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	US. 14. Race - Am. Black, Whi Specify: WH	erican Indian, te, etc.
ygiene. Ser then "natural", or the t, the Musical Exemira Completed by Fu		15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Gir life	cedent's Usual Occup ve kind of work done of DO NOT use retired	during most of work 1)	ing	16b. Kind of Business	/Industry
and Mental Hygiene. Is marked other then aumatic event, the Ma	3	/ 17. Father's Name (First, Middle, Las	1)		BABY SITTE	18. Mother's Nam		CHILD CA	KE.
ls marke raumatic	2	CHARLIE YOUNG 19a. Informant's Name/Relationship					al Route Numbe	or, City or Town, State,	
Depa tment of Health Important: If Item 27 any injury or other tr once	-	NINA RUARK - SIS 20a. Method of Disposition 1 Darial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from State	20b. Place of Dis cemetery, co	position (Name of rematory or other place	ce)	Date	MARYLAND 2 20c. Location - City of HEBRON, MA	Town, State
Depa tm Importar any inju		21. Signature Funeral Service Lice			22. Name and Addre	ss of Facility BOU	INDS FUN	ERAL HOME, SBURY, MARY	INC.
pphysicien and strength and leading transit as the burial-transit action in the period of the physicien and leading the ph		23a. Part 1. Enter the disease, of corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	Gente	S	lmag	1	Approximate Interval Between Onset and Death
e attending id for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1☐Live birth 4☐Pregnant at 9☐ Unknown	2 Fetal death	B Ectopic pregnancy C Other (specify)	1		23d. Date of de Month	livery Day Year
een signed by th nould be detache		Part II. Other significant conditions	contributing to death b	uf not resulting in the	underlying cause giv	en in Part I.		obacco use confribute t 'es 2 ☐ No 3 ☐ ♣	o the cause of death?
cate has bee page 2 shot							24a. Was a autop perfor	sy prior to death?	utopsy findings availat completion of cause o s 2 \sumbox No
ter this certific		25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Oeath 1 Accident investigatic investigatic	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		of 28c Injur	4 Larrursing Ho	ome 5 Resid	ne) lence 6 Other (Spenow injury occurred	ocify)
rs after death, ol Director: After tied in by the funera Certification:		3 Suicide 6 Could not determined	286. Place of in	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or R m, State)	lural Route Number,
within 24 hours after death. To the Funerel Director: All completely filled in by the funerel Medical Certification				f examination and/or				cause(s) and manner a date and place, and du	
To the comp		29b. Signature and title of certifier	Men		29c. Licens	e number	9	29d. Date signed (Mon	th, Day, Year)
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DHMH 17 Rev 1/2001

ORIGINAL

		·	1 = For State Registrar	State of Maryla		artment of H		lental Hygier	THUE	03631
	Physici /Medio		1. Decedent's Name (First, Middle, I	ast)	LDF	RICH		2. Date of Death	Day Year 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, g PLEASANT VIEW	ive street and number) NURSING HON	ΛĒ	4b. City, Town, or	Location of Death		4c. County of Dea	90 71 90
	Funeral Director		218-24-0802	Sex 7. Age (In yrs	s. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	ar)C	rthplace (State or Foreign ountry)
	the Maryland 28e-f show	or	Usual Residence of Decedent 10a. State 10b. County	10c. c	City, Town or L	ocation	=P		1498	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	sa or 28e	I Director	10e. Street and Number	D OR		10f. Zip Code	27	10g. (Citizen of What C	country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23a or 28e-f show or other traumatic event, the Medical Everthan Institute Incility of an or other traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1	U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0036	within 72 hours aft ene. then "naturel", or the Medical Ere.	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work	ing 16b.	Kind of Business	s/Industry
nd 2121	should be filed within and Mental Hygiene. marked other then imatic event, it. Mi	Be Com	17. Father's Name (First, Middle, La		NU	RSES	AIDE 18. Mother's Name	e (First, Middle, Maide	EAUH en Sumame)	ICARE
Maryland	2 should to and Ment le marked aumatic e	인	MADISON MD 19a. Informant's Name/Relationship	NRDE PRO	19b. Maili	ing Address (Street	NINA and Number or Rura	BELLE al Route Number, City	LYLES	Zip Code)
	as 1 and 2 of Health a item 27 le rother trau		ROBERT GAGN 20a. Method of Disposition	20h 150N 20h.	Place of Disp	DEISY osition (Name of		ODBINE Date 20c.	MD 6	2\1797 r Town, State
altimore,	t. Pa tmen tant: njury		1 Burial 2 Cremation 3	city) A	VAIDIN	matory or other place	EG 2/10	106 HF	4NOVE	R, MD
Bal	Depar Impo eny ir		21. Signature of Funeral Service Lic	ensee	2	2. Name and Addres	ss of Facility ANA	TOMY GIFTS R	21076 DEIVE	:
-	Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused the de- ly one cause on each line.	ath. Do not en	ter the mode of dyin		or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse		0	money	Disease		Yem
	uted 1 Insit	mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						
8760,	certificate be executed Iding physician and Ise as the burial-transit	cal Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
9	eath certificat attending phy for use as th	/Medi	IF FEMALE:	23c. If yes, outcome of preg	nancy		,		23d. Date of de	Shory
P.O. Box	law requires that the death as been signed by the atten 2 should be detached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
	w requires the	þ	Part II. Other significant conditions H		esulting in the u	underlying cause give	en in Part I.	23e. Did tobacco	/	to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law re ate has bee bage 2 sho	Completed	HYPERT DEMEA CORONA	ITIA. RY BRTERY S	DISEAS	0.		24a. Was an autopsy performed2	prior to death?	autopsy findings available completion of cause of
ital	ien: Th artificate ctor, pa	Be Co	25. Was case referred to medical examiner?		13203		26. Place of Deat	1 ☐ Yes 2 ☑ N n (Check only one)	4o 1 □ Ye	s 2 1 No
of V	ding Phyeicien: The lav h. After this certificate has funeral director, page 2	ို	1 Tes 2 No 27. Manger of Death	Hospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury	y at	me 5 Residence 28d. Describe how in		ecify)
ision	Attending r death. sctor: After by the fune	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion be 390 Bloom of Injury. At	Injury		K? Yes 2□No	28f. Location (Street	and Number or E	Pural Pouta Number
Div	itel or A		4 Homicide determine	building, etc. (Spec	oify) 			City or Town, Sta	ate)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 ✓ Certifying (Check only one)	Physicien: To the best of my ki eminer: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	Tor	Σ	29b. Signature and title of certifier	all-be		29c. License		29d. C	Date signed (Mon	6,2006
			30. Name and address of person who N. R. VELLANKS, &&	so columbia.	em 23a) (Type	Print) PRKWAY A	1-308	Glumbia	. No.	21045
	Sta Registr	•	31. Date filed (Month, Day, Year) FEB 0 9	32. Registrar's Sign		Sparke)				

			_ For	State of Marylan			Mental Hygiene	9106 0	3632
			1 - State Registrar		Certificate	of Death	Reg. No	o	000
	Physici /Medic		1. Degedent's Name (First, Middle, Last)	hulette	Addisc		2. Date of Death Month Da	ау ^{Уеаг} 4 2006	3. Time of Death
7	Examir Funeral Director		4a. Facility Name (If not institution, give s Memori 5. Social Security Number 6. Sex 715-58-423 4	al Hospia	toL Branch Branc	vm, or Location of Death Year If Under 24 Hrs. Year Hours Min.	ore 40	9. Birthpla	ace (State or Foreign y) Uand
	72 hours after death with the Maryland natural', or itema 23a or 28a-f ehow iteal Exeminer must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County	Bo City	y, Town or Location	و	10.0		d. Inside City Limits
	ath with the 23a or 2	rai Dir	12.33 N· Luz	erne A	ر ا ا ۱۵۲ کار کار کار کار کار کار کار کار کار کار	213	(itizen of What Countr	
980	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 ie marked other than "netural", or itema 23a or 28a-f ehow other traumatic event, the Medical Examinar mast be collified as	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, et	
21215-0036	within 72 ho ene. then "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary (0-12)	cation e <i>completed)</i> Coltege (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use i	done during most of wor		Kind of Business/Indu	ıstry
	ould be filed with Mental Hygiene arked other than atic avent, the	o Be Co	17. Father's Name (First, Middle, Last)	lic You	Labor	18 Mother's Nar	me (First, Middle, Maider		\mathcal{J}
Maryland	nd 2 should lith and Men 27 ie marke r traumatic	ř(19a. Informant's Name/Relationship (Ty)	20. Philyusburg	19b. Mailing Address (S	itreet and Number or Ru	ural Route Number, City	or Town, State, Zip C	7) 2121
Baltimore,	Page nent o ant: if ary or		20a. Method of Disposition 1 Gaurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	Place of Disposition (Name emetery, crematory or othe COSON FORE 22. Name and	of place) 2/1 St (emeters) Address Famility	0100 _	ocation - City or Tow Ings Mil Second	ILS MD
ñ	permit. Departrimports eny inje		> Eun -W.	Sur	Variable	5 yar	ld Ballo	MD 2121	12
	Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	h. Do not enter the mode of		c or respiratory arrest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions	Bue to (or as a consequence of the perfension of the perfect of the perf	uence of): ON				5 yrs
J	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Du∮tú (ur as a cunsedi	uande (if):				
68760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	uence of):				
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta: 4 □ Pregnant at time of de	I death 3 Ectopic pregi			23d. Date of delivery Month D	y Day Year
٥.	equires that ten signed by the signed by the details and the details and the details are the signed by the signed	Ď	Part II, Other significant conditions con	tributing to death but not res	ulting in the underlying caus	se given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the	. 1
Vital Records,	: The law requ cate has been page 2 should	Completed					24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{V} \) No	24b. Were autops prior to complete the death? 1 Yes 2	sy findings available pletion of cause of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		Other	ath (Check only one)		
of	ding Physician: The h. h. After this certificate ha funeral director, page	lon: To	27. Manner of Death 1 Alatural 5 Pending	28a. Date of Injury (Month, Day Year)		Injury at Work?	fome 5 ☐ Residence 28d. Describe how inju		
ivision	or Attending I fter death. Nrector: After n by the funer	rtification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, street, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Stat		Route Number,

To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

29b. Signature and title of certifier

AT2438946

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

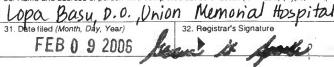
BALTIMORE: MARHLAND 21218

State Registrar

Medical Certifi

29a. Certifier

FEB 0 9 2005



CPM D6-00862 Martrell Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie Reg.	Com Col Col Col	03633
	Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Death Month February	°83, 2006	3. Time of Death
	/Medic	cal	MARTRELL BR 4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of Death		4c. County of Death	20:50 M
	Examir	ier	Johns Hopkins Hos		Baltimore		N/A	
	Funeral Director		220-23-3073	ox 7. Age (In yrs. last birthda) □ M 2□ F 16 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp Cour MAI	place (State or Foreign ntry) RYLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location	 	1	0d. Inside City Limits
	Mary P-f ehc	tor	MD N/A	BALTI	MORE CITY			YPes 2□No
	death with the Maryland ms 23e or 28a-f ehow must be notified at	al Director	10e. Street and Number 812 NAT COURT,	APT. #12	10f. Zip Code 21212	10g.	Citizen of What Cour	ntry?
0030	n 72 hours after death with the Marylan "naturel", or Items 23e or 28s-f ehow edical Examinar must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZY No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 MNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
1212-0	within 72 ho ene. then "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 0 T H	College (1-4or 5+) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) O SERVER	MO	Kind of Business/Inc CDONALD'S ESTUARANT	3
2	filled Hygi other	a)	17. Father's Name (First, Middle, Last)	FOOL		e (First, Middle, Maid		CORE.
lan I	uld be Mental irked c	To B	ARTHUR T. BRO	WN, JR.	SHYREE	ESE K. DA	ANIEL	
, mary	s 1 end 2 should f Heelth and Men tem 27 le marke other traumatic		19a. Informant's Name/Relationship (7 SHERYL A. DANIE	L PARK/GRAND 14	ling Address <i>(Street and Number or Rur</i> 108 GITTINGS AVE			
more	00		20a. Method of Disposition Durial 2 Cremation 3 4 Donation 5 Other (Specify	TOODT'A	position (Name of permatory or other place) IN CEMETERY 02/1		. Location - City or To ALTIMORE	
palt	permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service Licens	See 8. Navy	22. Name and Address of FacilityHOW 4600 LIBERTY HE			
	Physician /Medical Examiner	Iner	Immediat Cause (Final dise is if condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a consequence of): Due to (or as a consequence of):	11 11 1			Approximate Interval Between Onset and Death
8/00,	icate be executed physicien and s the buriat-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
200	ificate be g physicie as the bur	edicai		d				
C. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours efter death. To the Funeral Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
ras, r	quires that n signed bi	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	11
al necor	:: The law reicete has bee	Completed				24a. Was an autopsy performed	? prior to cor death?	psy findings available mpletion of cause of
	siciar s certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatie	Other	h (Chleck only one)	6 □Other (Specifi	
Sion of	nding Phy tth. :: After this e funeral c	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury 2145		28d. Describe how in		,,
DIVIS	al or Atters s efter dea	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rura	Route Number,
	he Hospit n 24 hour he Funers	edical	29a. Certifier (Check only one) 1. Certifying Phyone) 2. Medical Example 1.	rsician: To the best of my knowledge, dea iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the comp	M	29b. Signature and title of certifier	1 3/ 1/	29c. License number	29d.	Date signed (Month,	Day, Year)
			I beoden M	. Ling mus	O.C.M.E.	Fe	bruary 04	, 2006
	7		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type $-Q$	Penn Street, Balt:	imore. Mar	ryland 2120	01
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Country .	-,		
	negisti	41	FEB 0 9 20	06 January D. A.	430			

			1 - For State Registrar	State of Marylar		nent of Health and cate of Death	Mental Hygien	. UUU	03634
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last, ALPHA 4a. Fecility Name (If not institution, give	BAN		City, Town, or Location of Deal		3,2006 c. County of Death	3. Time of Death 7:00 A-M
	Examin Funeral Director	er	BON SECS 5. Social Security Number 6. Sec 232-52-8948	ours Hosp	1/AL	BALTIM Inder 1 Year If Under 24 Hrs	B. Date of Birth	9 Birth	place (State or Foreign intry)
	th the Maryland or 28a-f show e notified at	Director	Usual Residence of Decedent 10a. State 10b. County 10e. Steleet and Number	10c. Ci		OPE f. Zip Code	10g. C	citizen of What Cou	10d. Inside City Limits 1 XYes 2 □ No untry?
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23s or 28s-f show ant. Its Madical Examinar must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes, 201 No If Yes, Give Year or Dates:	J.S. 13. Was E	2/2/7 Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puer es 21/2/No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
d 21215-0036	be filed within 72 hours after death with the Marylan Hygiene. do ther than "natural", or Itams 23a or 28a-f show avant, Ite Maulical Examinating the notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give kind of life. DO No	Usual Occupation of work done during most of wo of use retired) 18. Mother's Na.	rking 16b.	Kind of Business/In	Homes
arylan	2 should be and Mental is marked of raumatic ave	To Be	John Leon 19a. Informant's Name/Relationship (7)	Scales pp. Print) (sister)	19b. Mailing Add	dress (Street and Number or Ri	nia S	trickle	and p Code) 20002
o,	es 1 an of Heal fitam 2 r other		20a. Method of Disposition 1 Disposition 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Disposition cemetery, crematory	(Name of or other place)	Pate 20c. L 2006 F	Shingte Location - Gill or T Balto.	Yown, State
Bail	permit. Pag Dapartment Important: I any injury o		21. Signature of Funeral Service Licens 23a. Pant. Enter the disease, or complete shock, or heart failure. List only or	L. Buss	Jose	- W. North Ave	Funeral H Balto, M correspiratory arrest,	ome, P.A d. 21216	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseq	EUMO Quence of): BRE	XIA			Interval Between Onset and Death
3/60, <	certificate be executed ding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	quence of): OBSTRUC	TIVE PULM	NOMA OKARY DIS	EASE	
ň.	ath certific	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectop	oic pregnancy r (specify)		23d. Date of deliv Month	ery Day Year
λ, J	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underly	ng cause given in Part I.	23e. Did tobacco	_	the cause of death?
Hec	The law ate has b page 2 st	e Completed	OF Was assa salarrad to martial				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
5	this aldi	To B	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ath (Check only one) lome 5 Residence 28d. Describe how inju		(y)
DIVISION	I o tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specify	(y)	ctory, office	28f. Location (Street a City or Town, State	re)	
	Io tha Hos within 24 h To tha Fur completely	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	ation and/or investiga	ation, in my opinion, death occu	rred at the time, date an	d place, and due to ate signed (Month,	o the cause(s) Day, Year)
	3		30. Name and address of person who co	empleted cause of death (Item	m 23a) (Type, Print)	D003035	COURS	HOSP	TAL
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 9 20	32. Registrar's Signa	ature	U		•	

			1 - For State Registrar	State of M	farylan		artment tificate			and Me		giene Reg. No.	06	03635
100	Dhysioi	20	1. Decedent's Name (First, Middle, Last)								Date of De. Month	ath Day	Year	3. Time of Death
	Physici: /Medic	A 3	LARRY ELDON								Februa:	_		11:40 p M
	Examin	er	4a. Facility Name (If not institution, give s				-		Location of	ol Death			County of Dea	
	4		6410 Old Sandy Sp 5. Social Security Number 6. Sep			last birthday)	Lau		If Under	24 Hrs.	8. Date of Bir		nce Ge	thplace (State or Foreign
	Funeral Director			M 2□F	59	Yrs.	Months		Hours	Min.	Month, Da June 1!	y, Year)	C	lifornia
jā.			Usual Residence of Decedent									, 25		
	nylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Be-f	cto	MD Prince G	eorge's	L	aurel								1 ☐ Yes 2 ☐ No XX
	with the	吉	10e. Street and Number 15435 Arbory Way				10f. Zip	0707					en of What C	ountry?
	within 72 hours after death with the Maryland ene. Then "natural" or Iteme 23a or 28e-f ehow Ite Madical Examinar , ust be malified at	Funeral Director		12. Was Deceder	nt Ever in U	S 13 V				gin? (Spe	cify Yes or No	U.S	4. Race - Am	erican Indian,
	tter d	Fun	1 Never Married 2 Married	Armed Forces	:2	64-					cify Yes or No Rican, etc.)		Black, Whi	
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates	7.0	}	1□Yes 2	X No	Specify:				Specify: W	hite
S O	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usua kind of wor	I Occupa	ation <i>Juring m</i> os	t of working	ıg	16b. Kin	d of Business	/Industry
7	ithin	Jq.	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of wor DO NOT us	e retired,)			_		
2	lled w Hygier ther ti		Grade 12 17. Father's Name (First, Middle, Last)			Dri	ver		18 Mothe	ar's Name	(First, Middle		inting	
and	ad of	Be c	Paul D. Brooks								. Nelso			
Maryland 21215-0036	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a			Route Numb		Town, State.	Zip Code)
<u>S</u>	od 2 salith ar alth ar treu		Jessica Brooks /	daught	er	15435	Arbo	ory V	√ay,	Laure	el, Mar	yland	3 2070	7
<u>ə</u>	f Heal f Heal ltem othe		20a. Method of Disposition		20b. P	Place of Dispo semetery, crer	sition (Nan	ne of ther place	a)	D	ate	20c. Loc	ation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Insportment: If tem 27 is marked other then "natural" or teme 23a or 28e-f show any injury or other treumatic event, the Markinal Examiner must be notified at once.		1 🖾 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		.0	Veter			1	2/8/2	006	Crow	nsvill	e, MD
<u>=</u>	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	99/										me, P.A.
<u></u>	82 2 2 3		I Krilly Ich	<u> </u>	M007	, 5					Laure		2070	
*			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caus ne cause on each	ed the deat line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Finat disease or condition resulting in death)	Metas	tatic	Lung	Cance	r						
2.17	/Medical* Examiner		resulting in dealth)	Due to (or a	as a conseq	uence ol):								
		J.	Sequentially list conditions,	Due to for a	as a conse	uence of):								
	nted I Insit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury											
G.	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	as a conseq	uence of):								
760,	te be ysicia ne bu	cal		d										
89	ntifica ing ph as th	Med	IF FEMALE:											
.O. Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom	2 Feta	death 3	Ectopic pr					2	3d. Date of de Month	Blivery Day Year
<u>.</u>	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (sp	өспу)						
۵.	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco us	se contribute i	to the cause of death?
ds,	uires l		Chronic Obstru	ctive Lu	ng Di	sease		_			1 🔀	Yes 2[]No 3□F	Probably 4 Unknown
Vital Record	s been si should	Completed									24a. Was		24b. Were a	utopsy findings available
æ	yeicien: The lav is certificate has director, page 2	E O										ormed? 2 13 No	death?	
ta	icien: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	e ol Death	Check only			Α
_	Physicien: this certific ral director.	To	I Tes 2LXIVO			ER/Outpatier			4 🗆 141					ecity)Asst. Liv.
u o	ding Phy th. After thi funeral	on:	27. Manner of Death 1	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time o Injury		Bc. Injun			8d. Describe	how injury	occurred	
Sio	Attending in death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	One Disease	Initiana At h	ana lasa st	M		Yes 2		ORL Location /	Street and	A Number or F	Rural Route Number,
Division of	or Attendate death Director:	Certification:	4 Homicide determined	28e. Ptace of building,	etc. (Specif	fy)	eel, lactory	, once				wn, State)		idia nosto remon.
_	To the Hospitel or Attenwithin 24 hours after deatl to the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying Phy	sician: To the be	st of my kno	owledge, deat	h occurred	at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner a	as stated.
	the Horin 24 h the Fur npletely	edical	(Check only 2 Medical Exami	ner: On the basis and manner		ation and/or in	vestigation	, in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and du	e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1/ 1	1			c. License	e number			29d. Date	signed (Mor	nth, Day, Year)
)	7		Allenone J.	15995-	Jun M	uc l	0	D28	U79		- 1	Fe	bruary	6, 2006
1			30. Name and address of person who c					7.7	Dec	D = 3 !	/77	14-		
			Francine A. Higg 31. Date filed (Month, Day, Year)	_					Dr.,	Reit	sville	, MD		
	Sta Regist		FEB 0 9 20	06	ر معان	ature	parke	P						

		1 - For State Registrar	State of	Marylar			nt of H te of L		ınd M	lental Hy	giene Reg. No.	00	5	03636
Bhyoir	ion	Decedent's Name (First, Middle	, Last)				•			2. Date of Dea	ath Day		Year	3. Time of Death
Physic /Med		Alberta Jo 1	Baker							Februar		, 20		11:00 P M
Exami	iner	4a. Facility Name (If not institution,	give street and num	ber)		4b. City	, Town, or	Location of	f Death		4c.	County	f Death	
1	j\$	Laurel Regiona					urel					-		orge's
Funeral Director		577-48-3865	6. Sex 7	'. Age (In yrs.		Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da June 18	y , $Y \Theta a r$)	937	9. Birth Cou Ind	place (State or Foreign ntry) 1ana
pus *		Usual Residence of Decedent 10a. State 10b. County		10c Cir	ty, Town or Lo	cation								10d. Inside City Limits
sho	ក		Coormala											1√√∑Yes 2 □ No
the A	Director	10e. Street and Number	e George's		Laurel	101.7	p Code				10g. Citi:	zon of W	hat Cau	
with		910 8th Street	L.			101. 2	207	0.7			-		nat cou	nu y :
death with the Maryland me 23a or 28a-f show Limbal be notified at	era	11. Marital Status	12. Was Deced	dent Ever in U	I.S. 13.	Was Dece			nin? (Spe	ocify Yes or No		JSA 14. Race	- Ameri	can Indian,
idifyiditid < 1 < 10.0000 2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other then "naturel", or Iteme 23s or 28s-1 show aumatic event, the Hedical Examinat must be notified at	by Funeral	1 ☐ Never Married 2 🛣 Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	ces? XXX No		lfYes, spo 1 □ Yes		n, Mexican, Specify:	Puerto	ecify Yes or No- Rican, etc.)			, White,	
Poor is how		15. Decedent		.00.	16a. Dece	dent's Usi	al Occupa	ation			16b. Kir	nd of Bus	iness/In	dustry
7 uin 72	ompieted	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	4	(Give	kind of w	ork done d ise retired,	luring most	of worki	ng				
I with	E	8th	College (1	40r 5+)	Home	makeı	<u>.</u>					Owi	т Но	me
ent,	0	17. Father's Name (First, Middle, L	ast)					18. Mother	r's Name	(First, Middle,	Maiden			
Id be file fortal Hyrked oth	To B	Joseph Zowd						Tr	ene	Hickley	7			
ife, Matyld s 1 and 2 should if Health and Men liem 27 is marke other traumatic		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Addres	s (Street a			I Route Numbe		r Town, S	itate, Zip	Code)
> == ~ =		Ronald Baker/Hu	ısband		910	8th S	Stree	t, La	urel	, MD 2	20707	7		
S 1 a		20a. Method of Disposition		20ъ. Г	Place of Dispo cemetery, crei	sition (Na	me of	a)	0	ate	20c. Lo	cation - (City or T	own, State
Page Page ent ont: If		1 ☐ Burial 2 ②Cremation 4 ☐ Donation 5 ☐ Other (Sc		(ater	st Aru			- 1	2/8/	2006	Oder	nton	MD	
Dallinore, r permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other?		21. Signature of Funeral Service L	icensee	I	22	2. Name a	nd Addres			aldson				e, P.A.
Depa Impo Inpo		2 Januaro	DOOK DOOK)мо11	03 3	13 Ta	lbot	t Ave	nue,	Laurel	, MI	20	707	
		23a. Part1. Enter the disease, or	complications that ca	used the deal	th. Do not ent	er the mo	de of dying	g, such as o	cardiac c	or respiratory ar	rest,			Approximate Interval Between
Physician		shook, or leart failure. List of Immediate Luse (Final	only offerause offera	on ime.	0 -	- (-					- 1	Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (o	r as a course	uence of):	n	ey						+	
Examiner			I. To	- ~ W	ina	lle	1_	ill	7					
-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	uence of):	6								
o rou, cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	\mathcal{C} .	ehy	dr	a	Tai	^						
O, exec en ar rial-ti		resulting in death) Last	Due to (o	r as a conse	uence of):		^							
or ou	dicai	8	d. M.	ente	2	Co	not	ut	ů	n,_				
rtifica ng ph	Jed	IF FEMALE.												
. C. DOX 00 (00), the death certificate be executed by the attending physicien and sched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 Peta		Ectopic r	regnancy				2	23d. Date		
dea death	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of c		Other (s						Mon	th	Day Year
by the	h	9 Unknown	1											
The Colds, 7.0. Box of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying	cause give	en in Part I.			obacco u res 2 [bute to t	he cause of death?
law reas bee	ompieted									24a. Was		24b. W	ere auto	ppsy findings available impletion of cause of
nysician: The law hysician: The law his certificete has t	Eo										rmed?	de	ath?	
	O	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 No	11	res	2□ No
ysicie s cer direct	To B	examiner?	Hospital: 17 In	patient 2	ER/Outpatier	nt 3∏ D	OA Othe	.61		me 5□Resid		Othe	r (Snecii	5v)
g Phy er this		27. Manner of Death	28a. Date of		28b. Time of		28c. Injury	at		28d. Describe h				7/
e fun all	atio	2 Accident 5 Pending		, Day (Gai)	Injury	М	Work 1 □ Y	r res 2□N	No					
r Attending for death. irector: Afte	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place C	of Injury - At h	ome, farm, str	eet, facto	y, office			28I. Location (S City or Tox	Street and	d Numbe	r or Rur	al Route Number,
s after	Cert		Duiding	g, etc. (Specil	77/					Only of Tov	, JId10,	,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier Certifying (Check only one)	Physician: To the be examiner: On the bas and manne	sis of examina	owledge, death ation and/or in	n occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the e	cause(s) date and	and mar place, a	ner as s	stated. the cause(s)
ompl	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date	e signed	(Month,	Day, Year)
)	1112	101.	1 . ~	nn	155	40	3		21	570	06	
1		30. Name and address of person v	who completed cause	of death (Iter	n 23a) (Tvde	Print)		J. 44.7	60-	Allsins	A PAN	40	un	20910
0		30. Name and address of person v	HIMN	MD,7	610 CA	PROC	LAU	CHI	00 1	11001-11	. V #1 P	,,	U	00112
S S	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature									
Regist		EED 0 0	2000		L	1 .								

DHMH 17 Rev 1/2001

ORIGINAL

_			1 - For State Registrar	State of	Marylan	•			lealth a Death	nd M	•	giene Reg No	006	03637
	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	Dav	Year	3. Time of Death
	/Medic Examin		Charles Brech 4a Facility Name (If not institution, give s BALLIMURE VAME		Cen	ter	4b City	1 7 5	r Location of	Death	Feb.	4c. (County of Deat	
	Funeral Director		5. Social Security Number 218-46-7522 6. Sex 123 Usual Residence of Decedent	M 2□F	Age (In yrs.	last birthday, 58 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da May 31	y, Year)		hplace (State or Foreign untry) Maryland
797	death with the Maryland me 23s or 28s-f show finant be notified at	Director	10a. State 10b. County Maryland Baltin	nore	10c. Cit	y, Town or L			altimo	re				10d. Inside City Limits 1 ☐ Yes 2 XNo
J	with the a or 2	Dire	10e. Street and Number 312 Nicholson Re	oad			10f. Zi	p Code	1221			10g. Citiz	en of What Co USA	untry?
Q	death w	Funeral		2 Was Doseda	ent Ever in U	.S. 13.	Was Dece			in? (Spe	cify Yes or No Rican, etc.))- 1·	4. Race - Ame	
M 2003	within 72 hours after ane. than "natural", or Ite ne Madical Examina	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 X Yes 2 If Yes, Give Year or Date	BS 7 □ No BS:1965-		1 Yes, spe		sn, Mexican, Specify:	Puerto F	(ican, etc.)		Black, White Specify:	White
es Bi 7522 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mentel Hygiene. If them 27 Is marked other than "natural", or iteme 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		or 5+)	(Give	DO NOT	ork done d use retired	during most		g		d of Business/ Auto Manufac	Industry
	be filed htal Hyg hd other	BeC	17. Father's Name (First, Middle, Last)			1				's Name	(First, Middle	, Maiden S	Sumame)	
y Sal	should b nd Ments marked umatic e	To I	William Joseph		r						se Mary			
Charle - 46 - 6, Maryland	d 2 sh th and t7 le m traum		Christina M. Christ		hton	1							Town, State, 2	
	s 1 an f Heal Item 2 other		Christina M. Smytl 20a. Method of Disposition		20b. P	lace of Disperentery, cre	osition (Na	me of			BAILI		MD 21 ation - City or	
2/8- altimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	319	tro Cr	-	•	· 1	2/9/0	06	Ba	altimor	e, MD
Balt A	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Livense Edward A. Gre	gorchik	•	2	2. Name a 299]	nd Addres Frede	ss of Facility	Crei Road	mation Balt:	Soci		MD, Inc.
	Physician /Medical		23a. Part1. Enter the disease of complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on eac	h line.		ter the mo	de of dyin	g, such as c	ardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	ate be executed XX hysicien and ine burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequate as a consequate	vence of):								
687	at y d	edical	d.											
Division of Vital Records, P.O. Box	Attending Physicien: The law requires thet the death certific reasth. reasth. ector: Atter this certificate hes been signed by the attending p ector: Atter this certificate hes been signed by the attending by the funeral director, page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal tat time of d	death 3	⊒Ectopic p ⊒ Other (s					23	3d. Date of deli Month	ivery Day Year
rds, P	w requires thet been signed b should be deta	<u>م</u>	Part II. Other significant conditions conf	tributing to deat	h but not resi	ulting in the u	undertying	cause give	en in Part I.					the cause of death?
l Reco	The law re cate hes been page 2 sho	Completed						-			24a. Was autor perfo		24b. Were au prior to death?	topsy findings available completion of cause of
Vita	ysicien: 1 is certificat director, p	Be	25. Was case referred to medical examiner?	ospital:				Othe	200		Check only o			
of	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of I	njury	ER/Outpatie 28b. Time o		28c. Injury Work	4 U Nur		e 5 Residente la R		Other (Spec	city)
ion	ttending F death. stor: After / the funer.	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	м		<br Yes 2 □ N	lo				
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho etc. (Specif)	ome, farm, st	reet, factor	y, office		2	8f. Location (3 City or Tox	Street and wn, State)	Number or Ru	iral Route Number,
	Hospital or 24 hours afte Funerel Dir etely filled in	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	er: On the basis and manner	s of examina:	wiedge, daat tion and/or in	tti occurred ivestigation	at the time, in my op	ne, date and pinion, death	place, at occurre	nd due to the d at the time,	cause(s) a date and p	nd manner at place, and due	statud. to the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	_			29	c. License	number			29d. Date	signed (Montl	n, Day, Year)
	1		Fine M. B	nown	M.I	>.		91	966	7		F	b 7	2006
_	Hx,		30. Name and address of person who cor	NU.		23a) (Type,	Print)	eople	Stre	efs	BACTIO	nure,	MS.	21201
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 9 2006	32. Reg	istrar's Signa	lure .	W							

,	Type or Print in Bia	ck indelible ink.	Ensure All	Copies Are	regip
	State of Maryland /	Department of H	lealth and Me	ental Hygiene	00

it	chell 1	3ri	iggs Jr.	State of Maryland	/ Depart	ment of Health and	Mental H	/aiene a		00000
			1 - For State Registrar	Clair Critical y tarris		ficate of Death		Reg. No.	Ub	03636
	Physici	an	1. Decedent's Name (First, Middle, Las	*D · -	To		2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic	al	Mitchell	Briggs	UK	•	Februa	-	2006	16:34 P ^M
)	Examin	er	4a. Facility Name (If not institution, give			b. City, Town, or Location of Dea	ath	4c. Co	unty of Death	
	Funeral		Johns Hopkins Host 5. Social Security Number 6. S.	7. Age (In yrs. la	st birthday) 1	altimore Under 1 Year If Under 24 Hr		irth	9. Birthp	lace (State or Foreign
	Director		220-72-9572	XM 20 F 35	Yrs.	Ionths Days Hours Mir	8-2	ay, Year)	Ma	ryland
	and w.		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion			1	0d. Inside City Limits
	Maryl	to	WD	Ro	140	V CMD =				1 Yes 2 No
	h the	irec	10e. Street and Number		1111	10f. Zip Code		10g. Citizen	of What Cour	ntry?
	death with the Maryland me 23s or 28s-f ehow rmust be notified at	raiD	1572 (arsu	Jell Stree	+	21218		L	151	+
		by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Wa:	s Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Pue	Specify Yes or N irto Rican, etc.)	0- 14.	Race - Americ Black, White,	
5	hours after tural', or ite al Examina	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	1 🗆	Yes 2 No Specify:		Sp	acity: BI	ack.
2-003p	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation		t's Usual Occupation d of work done during most of w	orking	16b. Kind	of Business/In	dustry
Z	within 72 ene. than "nai	nple	Elementary Sedordary (0-12)	College (1-4or 5+)	life. DO	NOT use retired)	UNING	13	IEM	EC.
70	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Cas	18 Mother's No	ame (First, Middl	Maiden Su		savy
au		To Be	Mitaboll R-10	as So		len	110/	Vir	- 6	7
a	s 1 and 2 should Health and Mer Item 27 is marke other traumatic	Η.	19a. Informant's Name/Relations 👈 /	J. Print)	19b. Mailing A	Address (Street and Number or F	Rural Route Num	ber, City or To	wn, State, Zip	Code)
Z Z	and 2 paith a n 27 is		Lenuel Day	115 (Mother)	1572	Carswell	St. B	alp	MD	21218
9	00 O bu		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □		ice of Disposition of the control of	on (Name of ory or other place)	10 06	20c. Locati	on - City or To	own, State
	t. Page tment o tant: if tury or		4 ☐ Donation 5 ☐ Other (Specify) St.S	tanisla	rus (enreten)	' '	Bal	tina	re MA
ā	permit. Page Depertment Important: If any injury o		21. Signature of Funeral Service Licen	Suit S	V	ame and Address of Francisco	were	reval	Servi	ces A.A.
ı			23a. Part1. Enter the disease, or comp	plications that caused the death.	Do not enter t	he mode of dying, such as cardi	ac or respiratory	arrest,	MDZ	Approximate
Ł	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	MA. Harl.	and	+1)				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):	1 Wound		-		·
	Examiner	L	Sequentially list conditions,	b						
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to aminediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ance or,					
	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as a conseque	ence of):					
3/60	cate be ex physicien the burial	cai		d						
õ	death certificate e attending phys d for use as the	Med	IF FEMALE:						Ų.	
X Q Q	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of	death 3□Ec	topic pregnancy		23d	Date of delive Month	ery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5∐Oi	ther (specify)		ľ		ŕ
Ž.	s that	ьу Р	Part II. Other significant conditions of	ontributing to death but not result	ting in the unde	rlying cause given in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
cords	law requires that the death certifica es been signed by the attending pt 2 should be detached for use as i						10	Yes 2□N	o 3∐Prob	ably 4 Minknown
ď)	law re ss bee 2 sho	Completed					24a. Wa	s an 2	4b. Were auto	psy findings available mpletion of cause of
Ľ	The ste h	EOC					per 10//Yes	ormed?	death?	2 No
Vital	rsician: The law s certificate hes t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hamital.		7	eath (Check only	опв)	/	
=	£ = 5	٠ <u>۲</u>	1 XYes 2 No 27. Manner of Death		R/Outpatient _		Home 5 ☐ Res			y)
0	th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury 1534Ho	28c. Injury at Work? Mo 1 □ Yes 2 ☑ No	Selve C	+ Stol		
VISION	Atter	ifica	3 Suicide 6 Could not be 4 Whomicide determined	28e. Place of Injury - At hom			28f. Location	(Street and N	umber or Rura	A Route Number
5	Ital or rs afte al Dir led in	Certification:	- Direction	building, etc. (Specify)	at door a	Read Godworket	Ba (The	e, M	my laced	octsing their
	To the Hospital or Attending P within 24 hours atter death. To the Funeral Director: After to completely filled in by the funeral	edicai	(Check only 2 Medical Exam	ysician: To the best of my know inner: On the basis of examination			ce, and due to the	cause(s) and	manner as s	tated.
	o the ithin 2 o the smplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License number			gned (Month,	
	⊬ક⊨ંઇ	ļ	1 The one	1 X: x		O.C.M.E.	all additional and the state of		ary 05,	
	6		30. Name and address of person who	completed cause of death (Item :	23a) (Type, Prir		1	LCDLUC	.ry 07,	2000
	/ 7			•						

State Registrar

THEODORE MIKING 31. Date filed (Month, Day, Year) FEB 0 9 2008

32 Registrar's Signature Meson M

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar		of Maryla	-	artment of H tificate of L			Reg. No.	16	03639	
ı	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Dea Month					Day	Year	3. Time of Death 2:30 P			
		/Medical Catherine L. Brown Examiner 4a. Facility Name (If not institution, give street and number)						Location of Death	Februar		JU6 ty of Death	12:30 P™	
		Manor Care					Largo			Princ	ce Geo	orges	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🖫 F	7. Age (In yrs	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da			lace (State or Foreign	
	Director		269-34-4467 Usual Residence of Decedent		82	Yrs.			04/01	/1923	Ohio		
215-0036	yland low		10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits	
	Man B-f sh	tor	Maryland Prince	Georges		Landov	er					1 ☐ Yes 🍇 XNo	
	or 28	Jire	10e. Street and Number				10f. Zip Code			10g. Citizen o	What Coun	itry?	
	ath w	rail	6142 Osborn Rd.				207				J.S.A.		
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neturel", or Items 23e or 28a-f show event, I're Mydical Examinational Legisland at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	Armed F	X⊠ No live	1	Was Decedent of Hi fYes, specify Cuba I□Yes XX No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	BI	ace - Americ ack, White, ^{ify:} Whit	etc.	
	2 hou eture	ted	15. Decedent'	s Education		16a. Deced	lent's Usual Occupa	ition		16b. Kind of			
212	thin 7 e. an "n	Completed	(Specify only highest Elementary/Secondary (0-12)	1) (1-4or 5+)	life. L	kind of work done of OO NOT use retired	uring most of work)	ing				
7	filed wi Hygien sther th	Con		5		Tea	cher			Educa			
n n	0 = 0 >	Be	17. Father's Name (First, Middle, L					18. Mother's Name	e (First, Middle,	Maiden Suma	ume)		
Maryland	ages 1 and 2 should be int of Health and Menta t: If item 27 Is marked y or other treumatic ev	2	Unobtainabl 19a. Informant's Name/Relationsh	_		19h Mailin	n Address (Street a		tainabl		ity or Town, State, Zip Code)		
<u> </u>	and 2 s ealth an n 27 ls ser treu					305,800.0				1315-321-331	, otato, zip	0000)	
ē,	s 1 ar if Hea item		David L. Brown-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State										
altimore,	Pages nent of int: If its		1 ☐ Burial 2 反 € remation 1 ☐ Donation 5 ☐ Other (Sp	3 □Removal fron ecify)	I State		oln Crema		08/2006	Brenty	vood,	MD	
Balti	permit. Page Department I Importent: If any injury or once.		21. Signifure of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722										
			23a. Rand. Enter the disease, or o shock, or heart failure. List of	complications that	caused the dea	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
.2	nysician	K (Immediate Cause (Final disease or condition	DEMENTIA Ons							Onset and Death		
	/Medical Examiner		resulting in death)	Due to	Due to (or as a consequence of):								
	ZXXIIIICI	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	b								
	ited insit	mine	Cause (Disease or injury										
<u>_</u>	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	c	c Due to (or as a consequence of):								
09/89	icate be executed physician and s the burial-transit	edicai		d	_ d								
_	ntifica ng ph as th		IF FEMALE:										
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	utcome of pregn birth 2 Fet gnant at time of nown	al death 3	Ectopic pregnancy Other (specify)				ate of delive lonth	ry Day Year	
	res that t igned by be deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death									e cause of death?	
Vital Records,	quires nn sigr uld be	ed by	Cop	ONARY	प्रदेश ।	TERY	DUEA	SE	1 🗆 Y	es 2□No	3 Prob	ably 4 Unknown	
000	aw require s been siç 2 should b	Completed	HYPERTENSION							24a. Was an autopsy findings ava prior to completion of caus			
ř	rsician: The law s certificate has l lirector, page 2 s		performed						med2 2 ☑ No	death?			
<u>E</u>	stan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of Death					
	Physic this ca	2	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence										
Division of	death. ctor: After t y the funera	Certification;	27. Manner of Death Natural 5 Pending 2 Accident Investig	ation (Mo.	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 28c. Injury at Work? 1 □ Yes 2 □ No			28d. Describe how injury occurred					
	or f fter pire in b	ertific	3 ☐ Suicide 6 ☐ Could n. 4 ☐ Homicide determin	reet, factory, office 28f. Location (Street and Number or Rural Route Nu. City or Town, State)				l Route Number,					
	o the Hospital within 24 hours a To the Funerel C completely filled in	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) (Check only one) Check								ated. the cause(s)		
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. License	number	:	29d. Date sign	ed (Month, L	Day, Year)	
	4		· du	lenz	M	5	000	58290		2/7	106		
6)		30. Name and address of person v	no completed cau			Print)						
		ļ.,	SUTLIES (A) CUMPAR 1	MUTT ATI	+ 420	3 QUE	ENSBURY	Ry. 184	1) UZ 7740	LE MI	J 30	281	
	Sta Registr	_	31. Date filed (Month, Day, Year)	2006	egistrar's Sign	A A	ede						

		•	For State Registrar	State of Man	-	ertificate of	lealth and Me Death		ene No. 006	03640
			1. Decedent's Name (First, Middle, Last	")			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		AARON		131	AKNE	V	FEB. O	3 2606	6 11:00 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death	_	4c. County of Deal	th
			BLUE POINT	NURSI.	NG HOME	1 61	9LTIMO1		N	18
	Funeral		5. Social Security Number 6. Se	x 7. Age (li M 2 F	n yrs. last birthday	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y	(ear) 9. Bird	hplace (State or Foreign ountry)
	Director		011-06 0066	M ZUF	25 Yrs.			TAN. 28,		TRYLAND
	and *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d, Inside City Limits
	/anyli	ō	144 0.1/4 1/4	1 5		0	ALTIMON	pr 1	71/	1⊠Yes 2□No
	28a-1	ect	10e, Street and Number	IA		10f. Zip Code	PLIMO		g. Citizen of What Co	puntov?
	with with	Ö	812 A115	ILAME	STORET	-	21229		1154	7 .
	ns 23	by Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	. Was Decedent of H	Hispanic Origin? (Speci	ify Yes or No-	14. Race - Ame	erican Indian,
10	r Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No			lispanic Origin? (Speci an, Mexican, Puerto Ri	can, etc.)	Black, Whit	e, etc.
036	urs a		3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B	LACK
5-0036	72 hours after death with the Maryland Insturel; or Hems 23a or 28a-f show disal Examble must be notified at	Completed	15. Decedent's Edu	ucation	16a. Dec	edent's Usual Occup	pation during most of working	16	b. Kind of Business	Industry
21	Pan "r	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	′		<i>a a</i> .
7	od will	Son	9 THGRADE			CHE	<i>[-</i>		KODHOLH (DUNTRY CLUB
nd	al Hy	Be (17. Father's Name (First, Middle, Last)	1/	2 .		18. Mother's Name (First, Middle, Ma	uiden Sumame)	,
Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "naturel", or Items eumatic event, It a Medical Exant action	P	LEROV		BLAKN		ODESS	5A	1-1	OVD
a	2 sho and ts m	0 3	19a. Informant's Na e/Relationship (T		1 4 .	to a sec	and Number or Rural			
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, its Medical Exam has the notified at		MONICA BLAKNE				DERICK I	AVE, L	ALTIMOR	E. MO. 21229 Town, State
Baltimore	ges 1 it of H if Itel		20a. Method of Disposition 1X Burial 2 Cremation 3			ematory or other pla	ca)			1
Ë	Pages ment of ent; If It lury or o		4 □ Donation 5 □ Other (Specify,)	KING P.	ARK CEME	TERY 02-11	1-06 6	JOODLAN	IN, MARYLAND
at	permit. Page Department o Importent; If any injury or once.		21. Signature of Funeral Service Licens	300		22. Name and Addre	ss of Ficility BA	ROWN.	JR. FUNE	RAL HOME 4021217
ш_	20599			J. 100						
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the one cause on each line.	e death. Do not e	nter the mode of dyi	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician	æ.	Immediate Cause (Final disease or condition	. Hebst	ic er	cephol	00-19			Onset and Death
	/Medical		resulting in death)	Ou 10 (or as a c	onsequence of):					
	Examiner		Sequentially list conditions,	b. Coqqu	10 Poll	~~				
1	p is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):	_				
$\sqrt{}$	ecute and -tran	саш	that initiated events resulting in death) Last	c. Due to (or as	requence of:	1				
60,	cian cian curial			Due to (or as	394491109 01).					
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical		d						
9	ding p	by Physiclan/Me	IF FEMALE:	23c. If yes, outcome of	oregnancy				22d Date of do	liven
Вох	death c	lan	in the past 12 months?	1 Live birth 2 [4 Pregnant at tim	Fetal death 3	☐Ectopic pregnanc	у		23d. Date of de Month	Day Year
-	the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	ie or death 5	Other (specify) _				
P.0	w requires that the de been signed by the a should be detached	P	Part II. Other significant conditions co	entributing to death but r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	signe d be	d by				, ,		1 🗆 Yes	2 No 3 P	robably 4 Unknown
Ö	y requ	Completed						24a. Was an	24h Word a	utopsy findings available
360	e la has	ldm						autopsy	prior to	completion of cause of
a	Tate							1 ☐ Yes 2		2 🗆 No
of Vital Records,	uing Physician: After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death			
of	Phys this ral di	. To	1 ☐ Yes 2 No 27. Manner of Death	1 L Inpatient	2 ER/Outpation	ent 3 DUA	44CV Nursing Hom	e 5∐ Residen 3d. Describe how	ce 6 Other (Spe	cify)
L	fer	tlon	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) Injury	Wo	rk? Yes 2 □No		myary addanta	
Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be		- At home, farm, s			of, Location (Stre	et and Number or Ri	ural Route Number.
<u>>i</u>	or A after Dlred in by	ertif	4 Homicide determined	building, etc. (Specify)	Aroot, radioty, office		City or Town,		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phy	ysicien: To the best of r	ny knowledae, dea	ath occurred at the ti	me, date and place, an	id due to the cau	se(s) and manner as	s stated.
	24 h	edical		iner: On the basis of ex and manner stated	amination and/or					
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Mont	h, Day, Year)
	- > - ō		Amortun L	Marien		D	15503	1	Phryan	6 2006
	^		30. Name and address of person who o	completed cause of deat	h (Item 23a) (Tyo	a_Print)	1616		TI	MT
	3		AMA NULL 1	4 MARCE	m	0100	MININ S	>',13'	e/11 mor	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1		2121	
	Regist		FEB 0 9	2005	w K	how				

Certificate of Death

Months Days

4b. City. Town, or Location of Death

RANDALLSTOWN

If Under 1 Year If Under 24 Hrs.

Hours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

TZ=W HTS OU

FEB 0 9 2006

31. Date filed (Month, Day, Year)

CARTER

1**X** M 2□ F

HOSPITAL

7. Age (In yrs. last birthday)

57

State of Maryland / Department of Health and Mental Hygiene Reg. No.

Year

2006

BALTIMORE

14 Race - American Indian. Black, White, etc.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 X Yes 2 No

MARYLAND

BLACK

8:35 AM

2. Date of Death

FEBRUARY

8. Date of Birth (Month, Day, Year)

Day

3

4c. County of Death

10g. Citizen of What Country?

USA

Specify:

HOSPITAL

16b, Kind of Business/Industry

UNION MEMORIAL

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

FEBRUARY

MANDAUSTOWN MD

TODOR

Day

24b. Were autopsy findings available prior to completion of cause of death?

8

2006

21133

1 ☐ Yes 2 🔄 No

Month

2 1 No

PIKESVILLE, MD

Month

Physician /Medical Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

217-50-6289

FAMES

NO RTH WEST

4a. Facility Name (If not institution, give street and number)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

0846

HOSPITAL SHOT OLD COURT ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Items State of Maryland / Department of Health and Mental Hygiene
Item 17 per FH Certificate of Death Reg. No. Item 17 per FH Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Coffeld Sr. Month Russell)ames 8: DOPM 02 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12.08.1942 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 214.40.8429 63 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show I'm Medical Examiner must be notified at N/A Baltimore Director MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Park Avenue 21201 31009 USA Howard Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 Mo If Yes, Give Year or Dates: 9 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black ģ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", eny injury or other traumatic event, its Medical Exagnes. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem College (1-4or 5+) Elementary/Secondary (0-12) Ledman Steel Company Loth grade Maryland 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Sumame) Be Parita Washington Willie Cofield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cofield/Wife 3609 Howard Park Aue. Balto. MD 21207 Delores 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Woodlawn DZ. 10.06 Woodlawn MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
5/5/1980 1tmore National Pike Batto. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Months Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit certificate be executed Due to (or as a consequence of) Completed by Physician/Medical as attending to 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at id be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown been si 1 🗌 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No page 2 s certificate Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospic & 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or completely filled 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

md 80

3,2006

convery

Apmes

Field

21215-0036

Baltimore,

Box 68760,

o

Division of Vital Records,

Jason Black 31. Date filed (Month, Day, Year) FEB 0 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

660 I North Charles 32. Registrar's Signature

Registrar

29c. License number

00061199

Towson

MD

29d. Date signed (Month, Day, Year)

Feb 4, 2006

State of Maryland / Department of Health and Mental Hygiene 03643 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death FEBRUARY 5, 2006 Physician CAPLAN 11:40 PM **EDWARD** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE TOWSON HOSPICE OF BALTIMORE GILCHRIST CTR. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) APR. 18, 1922 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2□ F MD 83 216-18-3203 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov 1 X Yes 2 □ No BALTIMORE Directo N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 6300 RED CEDAR PLACE #204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 1 1 2 1 1 No If Yes, Give or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 🕱 Married WHITE 1 ☐ Yes 2 💢 No Specify: à 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) PLUMBING BUSINESS OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CAPLAN SHANE CLARA ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if it am 27 i 6300 RED CEDAR PLACE #204 - BALTIMORE, MD 21209 BEVERLY CAPLAN / WIFE Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of P Important: if Ita any injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State HEBREW YOUNG MEN CEM. 02/08/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Syneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Schemic Cardiomyopath Years /Medical Due to (or as a consequence of): Examiner S puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed/ certificete 1 ☐ Yes 2Ĉ 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ျှ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To the 29b. Signature and title of certifier D58303 February 6 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

-06/11.40pm

			1 - For State of Maryland / Departm Certific	ent of Health an		ene 0 0 6	03644
8	Physici /Medio	al	ISAAC DURHAM, SR.	Div. Town or Location of D	2. Date of Death Month Fe by va	Pay 7 2000	
<i>!</i> -	Examir	er	SINAI HOSPITAL E	City, Town, or Location of D A (+ 1 M C) nder 1 Year If Under 24	Re	N/A	
8	Funeral Director		5. Social Security Number 214-58-9427 G. Sex 1 MM 2 F 7. Age (In yrs. last birthday) Mon Usual Residence of Decedent		Hrs. 8. Date of Birth (Month, Day,) 09/13/	Year) Col. 1952 MA	place (State or Foreign intry) RYLAND
altimore, Maryland 21215-0036	Maryland	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE	CITY			10d. Inside City Limits XXYes 2 □ No
	h with the 23a or 28a		10e. Street and Number 2836 BOARMAN AVENUE	. Zip Code 21215	100	g. Citizen of What Cou USA	untry?
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow he Mulcel Exemither mark the motified at		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	ecedent of Hispanic Origin specify Cuban, Mexican, P as 2 X No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Specify: B.	
	within 72 hours iene. then "natural", the Modical Ex		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2.TH 16a. Decedent's (Give kind o life. DO NO 1/16) College (1-4or 5+) PRESS P	f work done during most of T use retired)	working	6b. Kind of Business/I	,
	should be filed withir and Mental Hygiene. marked other then matic event, the M		17. Father's Name (First, Middle, Last) TOURM DIDURM	18. Mother's MARY	Name (First, Middle, Ma		
	Health ar Health ar tem 27 Is		19a. Informant's Name/Relationship (Type, Print) ERNESTINE P. DURHAM / WIFE 2836 20a. Method of Disposition	ress (Street and Number of BOARMAN AV	E., BALTI	,	21215
	permit. Pages Department of Importent: If I any Injury or one		4 Bechalion 6 Bother (opening)	CEMETERY 0		LANDSDOW	NE, MD OME 21207
Records, P.O. Box 68760,	80 E # 9		23a. Parti. Enter the dispase, or complications that caused the death. Do not enter the	0 LIBERTY mode of dying, such as car	diac or respiratory arres	st,	PIMORE, MI Approximate Interval Between
	Pnysician /Medical Examiner		Immediate use (Final disease of Condition resulting in death) Sequentially list conditions b. MOCARDIA	INFAR	ny cardi:	Α ,	Onset and Death
	ate be executed nysicien and he burial-transit	icai Examiner	d				
	the death certifical by the attending phy ached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Other	ic pregnancy r (specify)		23d. Date of deliv	rery Day Year
	w requires that the de been signed by the a should be detached f		Partitional significant containers continuing to coath but not resulting in the discense	ng cause given in Part I.		acco use contribute to	3 6
	The lar				24a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
	nyeician: Th nis certificete director, pag	o Be			Death Check only one ng Home 5 Residen	on 6 DOther (Space	(A ₁)
n o	ng Pt ter th	edical Certification; To		28c. Injury at Work?	28d. Describe how		1197
Division of Vital	r Attenter deat irector:		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fair building, etc. (Specify)	1 Yes 2 No	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and p ttion, in my opinion, death o	lace, and due to the cau occurred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
١	To the comp	×	29b. Signature and title of pervitier	29c. License number D DOS 45		Date signed (Month)	
14.5	Sta	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print). FEDERICK SURVE, MD 240 W. I. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3e/vedevre	Ave-BA	(timor	e,M) 21215
4	Registr						

DHMH 17 Rev 1/2001

DURHAM SR, ISAAC

			1 - For State Registrar	State of M	laryland		rtment tificate			and M	ental Hygi	ene	06	03645
			1. Decedent's Name (First, Middle	, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Dwight Worth D	avis							Februar		2006	10:00 a ^M
)	Examin		4a. Facility Name (If not institution	-			-		Location of	of Death			y of Death Ltimo	* 0
			Greater Baltin				To If Under	OWSOI	1 If Under	24 Hre	O Data of Dish			
	Funeral Director		5. Social Security Number 227–20–3881	6. Sex 7. A 11X M 2 ☐ F	ge (In yrs. Iasi 79	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jun 23,		Cou	place (State or Foreign printy) prida
200	**		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							10d. Inside City Limits
Many	f eho	ŏ	MD Balti		Tows	aon								1 ∰ Yes 2 □ No
4	289	rec	MD Balti 10e. Street and Number	more	TOWS	5011	10f. Zip	Code			10	g. Citizen of	What Cou	ntry?
4	33a o	Funeral Director	1016 Roxleigh	Road			212	286				USA		
0	ma (ner	11. Marital Status	12. Was Deceden Armed Forces		13. V	Vas Deced	ent of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian,
d K I K I J-0000	is faint and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced		No LIJT		l □ Yes 2		Specify:		, now, now,	Speci	60	ite
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	and Mental Hygiene. Is marked other there. sumatic event, the	Be	17. Father's Name (First, Middle,									aluen Suma	me)	
X	nd Mental	2	David A. Davi			19b. Mailin	n Address	(Street a			tton Il Route Number,	City or Town	. State. Ziu	c Code)
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1)	f Health Item 27 other tr	1	20a. Method of Disposition		20b. Plac	e of Disponetery, cren						20c. Location	- City or T	own, State
	nage national national		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Jackso				2-9-0	6 N	lt. Ja	ckson	, VA
	Department of the programment of		21. Six ature of Funeral Service	Licens e		22	. Name and	d Address	s of Facilit	ty Del	linger I	unera:	l Hom	e, Inc.,
ם מ	8258		Lennes	tellme	ne	599	97 Ma:	in S	t., F	0 Bc	x 63, Mt	. Jacl	kson,	VA 22842
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Ine.	Do not ente	er the mode	of dying	j, such as	cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
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	/Medical xaminer		resolung in obalin)	1.	s a consequer	-								
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	ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetel de	eath 3□	Ectopic pro						ate of deliv	ery Day Year
5	ines trat are death certificate signed by the attending physid be detached for use as the t	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant : 9□Unknown	at time of deat	th 5∟	Other (spe	ecify)						
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2	n sign	d by	ren	al tail	ire	·					1 □ Ye	s 2 No	3 🗌 Prol	bably 4 Unknown
3	s been s	Sete									24a. Was ar		Were auto	opsy findings available
ב ב	te ha	Completed									autopsy perform	ned?	prior to co death? 1 \(\text{Yes} \)	empletion of cause of
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) i	oning Filyscoam. The law h. After this certificate has funeral director, page 2	lon:	27. Manner of Death 1 ♣ Natural 5 ☐ Pendin		jury Pay Year)	8b. Time of Injury		8c. Injury Work			28d. Describe ho	w injury occu	rred	
יוביי	death stor: ,	cat	2 ☐ Accident investion 3 ☐ Suicide 6 ☐ Could	not be 200 Place of It	niuny . At home	o farm str	M eet factory		/es 2 □		28f Location (Str	reet and Num	her or Rur	al Route Number.
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)	1		mork.	youres.	, MD		h	00	058	05	2	2/6	106	>
	5		30. Name and address of person	who completed cause of	death (Item 2:	За) (Туре,	Print)	7	D	11+0	550	Tours	1 A	D21204
c	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signalur	BARRE	(C.)	<u> </u>	00	1//	- 50	UVVSV	1 10/	VLICO
	Registr	rar	FEB 0 9 2	006 Jane	15	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 's Name (First, Middle, Last) Day **Physician** /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner 1+05pice Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F -58-1048 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: if item 27 ie marked other then "natural" or itemapate, or other fraumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2⊠0 Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) ndary (0-12) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Informant's Name/Refationship (Type, 19b. Mailing Address (Street and Number Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee Eun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** months disease or condition resulting in death) Cardiomyopath /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by tha attending physicien end page 2 should be detached for use as the burial-transit The law requires that the daath certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 1 Tes 3□ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? Natural 5 Pendina investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

838

address of person who completed cause of death (Item 23a) (Type, Print)

Hospice 32 Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylan		artment of F		R	leg. No. UUD	03647
	Physici		1. Decedent's Name (First, Middle, Last))				2. Date of Dea Month Februa	Day Year	3. Time of Death 5:51 P M
	/Medic Examin		Robert A. Derwart 4a. Facility Name (If not institution, give			•	r Location of Death		4c. County of Dea	th
	Funcial		2917 Erie Avenue 5. Social Security Number 6. Sec		ast birthday)	Parkvil	If Under 24 Hrs.	8. Date of Birth	Baltimo:	thplace (State or Foreign
	Funeral Director		217-40-3721	₹M 2□F 61	Yrs.	Months Days	Hours Min.	July 13		ryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Man	ctor	MD Baltimor	e P	arkvil.					1 ☐ Yes 2 ☐ No
	with the or 21	Director	10e. Street and Number 2917 Erie AVenue			10f. Zip Code	21234	1	10g. Citizen of What Co USA	ountry?
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36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f show the Mudical Exal-uther must be mullied at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:	•	Specify: wh	
2-00	72 hou natura	eted	15. Decedent's Edu (Specify only highest grad	ucation		dent's Usual Occup	ation during most of work	sina	16b. Kind of Business	/Industry
12	within and then then the Mass	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d)			
Maryland 21215-0036	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	2		lay out	person 18. Mother's Nam	e (First, Middle,	<u>printing</u> Maiden Sumame)	
<u>\</u>	d Menta	To	Andrew J. Derwan		10h Mailia	- Add-oo (Chaot		C. Ling	gg r, City or Town, State, .	Zin Codo)
<u>⊠</u>	nd 2 sl alth an 27 is r ir traur		John Derwart/brot	ton, MD	21047	Lip Godey				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural; or Iteme 23a or 28a-f show any injury or other traumatic event, the Mudical Extendible modified any once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	Date	20c. Location - City or	Town, State				
Balt	permit. Departr importa any inju		21. Signature of Funeral Service License Ronal	Wade Mreeton	St	Name and Addre ate Anat altimore.		1 655 W.	Baltimore	Street
			23a. Parti. Enter the disease, or compleshook, or heart failure. List only or	-	n. Do not ente	er the mode of dyin	ng, such as cardiac		rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate\Cause (Final disease or condition resulting in death)	a	eB/M uence of):	Henorth	age			
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68760,	ficate be executed physicien and s the burial-transit	ai Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
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	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the u	nderlying cause giv	ven in Part I.		ebacco use contribute le les 2 □ No 3 □ P	o the cause of death?
l Reco	24a. Wa auto page 2 should auto page 2 should auto page 3 should auto page 4 should auto page 5 should auto page 5 should auto page 5 should auto page 5 should auto page 6 should auto									utopsy findings available completion of cause of s 2 No
Vita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner? D∑XYes 2 □ No	Hospital:	FD/0-44	Ott	26. Place of Dea			at scene
So to the state of Death (Check only one) 24a. Was an authors of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Mayner of Death (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 28d. Describe how Work? 1 Yes 24a. Was an authors of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Mayner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factory, office 28f. Location (Stree City or Town, of Ci										city) at Secret
Divis	al or Atters safter des	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)		eet, factory, office		28f. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (relicians: To the best of my kno iner: On the basis of examina and manner stated.						
1	To the within 2 To the complet	Ž	29b. Signature and title of certifier	11/1/		29c. Licens			29d. Date signed (Mon	
1	91	ľ	30. Name and address of person to o	ompleted cause of death (Iten	n 23a) (Type.	O.C.N	1.E.		February 5	, 2006
1		li l	JACK MI	TIPL M.D.	11:	l Penn St	reet, Ba	ltimore,	Maryland	21201
-8	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 9 200	32. Registrar's Signa	iture	ide d				

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician 8:05 AM Karen L. Ellis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 966 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 27 F 39 217-76-0082 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County *Phow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dept riment of Health and Mental Hyglene. Important: if itsm 27 is marked other than "natural", or items 23s or 28s-1 show any righty or other trsumatic avant. It is Medical Examinar must be notified at once. 1 XYes 2 ☐ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 **USA** 1431 Cherry Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Management Department 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Russell JoAnn Gessner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Ellis, Husband 1431 Cherry Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/08/06 Baltimore, Maryland Metro Crematory Inc. 21. Signatura of Funeral Service Licensee ²² Name and Address of Facility Cremation Society Of Maryland 21228 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) A Physician ears /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day ş Month Year 4☐Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 1 ☐ Yes 2 No 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? Yes 2000 2 🗆 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No After this 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29b. Signature and title of certifier 125705 mo Les 30. Name and address of person who completed cause of death (m 23a) (Type, Print) Charles St. Bolto, Md BMC 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan		artmen rtificate			and M		giene Reg. No.	06	03649
5	District of		1. Decedent's Name (First, Middle,	Last)	<u> </u>						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		CAROL ANN	FRALEY							Februa	-	, 2006	12:20 a M
	Examin		4a. Facility Name (If not institution,					-	Location o	of Death			County of Dea	
100			Laurel Regional				Jaur If Under		If Under	24 Hrs	O Data of Bird			George 1 S thplace (State or Foreign
* 34	Funeral Director		169-32-0815	6. Sex 1 M 2 T	7. Age (In yrs. 64	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day June 9	, Year)	C	nnsylvania
	and and	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary	ō	MD Princ	e George	e's La	aurel								1 ☐ Yes 2√X No
	the 28a	Jec.	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?
	3a ou	Funeral Director	8601 Magnolia S	treet			20	0707				U.S	5.A.	
	death	Jere	11. Marital Status	12. Was D	ecedent Ever in U	.S. 13.	Was Dece	dent of Hi	ispanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	. 1	4. Race - Am Black, Whi	
9	or Ite	T	1 Never Married 2 Marrie	od 1 TY6	Forces? es 2 XX		1 🗆 Yes		Specify:	i, i doito	rtioari, oto.,		Canaifu	
<u> </u>	ours Fal',	d by	3 Widowed 4 Divorced	Year	or Dates:								. MI	nite
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2	within ne. han	m du	Elementary/Secondary (0-12) Grade 11	Colleg	e (1-4or 5+)		emaker)			O ToTa	n Home	
N D	Hygie Hygie ther i		17. Father's Name (First, Middle, L	ast)		HOME	maker		18. Mothe	er's Name	(First, Middle,			
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f ehow atic event, the Madical Examinar minial ke motified at	Be c	David Cornelius	,					Mari	e He	yden			
2	10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10d										Town, State,	Zip Code)		
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ē,	f Heal f Heal ltem othe		20a. Method of Disposition	4.40	20b. I	Place of Dispo cemetery, cre-	osition (Nar	ne of	(a)		Date	20c. Loc	cation - City o	r Town, State
Ê	Page ent o nt: If ry or		1 ☐ Burial 2 ⚠ Cremation 4 ☐ Donation 5 ☐ Other (Sp		om State	st Arur			ļ	2/	7/2006	Ode	enton,	Maryland
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m	Depa Depa Impo any is		1 GZ S.FV		/ M007/0	J	313 7	Talbo	ott A	venu	e Laur	el, i	Marylan	nd 20707
- 132 - 132			23a. Part1. Enter the disease, or shock, or heart failure. Lis of	complications th	at caused the dear	th. Do not en	ter the mod	de of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due	to (or as a consec	quence of):								
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	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		`									3 0 3
	and and Il-tran	Examiner	that initiated events resulting in death) Last	C	PD Exaces to (or as a consec		1							1 -2 days
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687	ficate p physics the			d.										
X	that the death certifica ed by the attending ph detached for use as th	ZW.	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		7:-					2	3d. Date of de	elivery
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ds, F	Attending Physician: The law requires that the death certifica robath. crobath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	d by Physician/Med	Part II. Other significant condition Tachy - Brady S		to death but not res	sulting in the u	ınderiying d	ause give	en in Part I	l. 		obacco u: Yes 2[to the cause of death? Tobably 4 □Unknown
00	w req	Completed	Coronary Artery	Disease	е						24a. Was		24b. Were a	autopsy findings available completion of cause of
Re	The law	E									autor perfo	osy ormed? 2XXNo	death?	
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	e of Deat	h (Check only o			
⋛	Physician: this certificaral director, p	To B	examiner? 1 ☐ Yes 2XXXVo	Hospital:	XInpatient 2] ER/Outpatie	nt 3 🗆 D0	Oth	er: 4□Ni	ursing Ho	me 5 Resi	dence 6	S □Other (Sp	ecify)
0	ng Ph fter th neral		27. Manner of Death 1 Watural 5 ☐ Pending	28a. D	ate of Injury Month, Day Year)	28b. Time of Injury	of 2	28c. Injun Wor			28d. Describe	how injury	occurred	
Sio	endil Bath. or: A the fu	cati	2 Accident investig	ation			М		Yes 2 🗆	No				
Division of Vital Records,	al or Att	Certification:	4 Homicide determi	ned 288. P	lace of Injury - At huilding, etc. (Speci	nome, farm, st ify)	reet, factor	y, office			City or To			Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier XXCertifyin (Check chily one) 2 Medical (Exeminer: On the	the best of my kn ne basis of examin manner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner and du	as stated. ue to the cause(s)
	To the To the Comple	Me	29b. Signatule and title of certifier	A	TEN	IK G			e number					nth, Day, Year)
	/		June 7		154751c	•	1 2	000	05	72	16	FE	EB 01	4, 2006
11			30. Name and address of person				, Print)			-				
1			Michael Baako,		300 Van I		Roa₫	Lauı	rel,	Mary	land 2	0707		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 9		2 Registrar's Sign		arty)							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Wendy Lea Fiedler February 06, 2006 3:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8406 Elko Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 53 Yrs Feb 25, 214-60-0858 1952 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 8406 Elko Drive 21043 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itame 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Iha Madin 2008. Howard County State's Elementary/Secondary (0-12) College (1-4or 5+) Attorney Office Paralegal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Savidus Ammann June Lorraine Wootten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon L. Fiedler /spouse 8406 Elko Drive, Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory | Feb 8, 06 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature Funeral Service Licensee M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rearrighted. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Due to (dr as a consequence of). /Medical Examiner METOSTOTIL (ancev OURNAND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown څ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed MOEN tensin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes rmed? certificate a 1 ☐ Yes 2 ☐ No ST12M0 1 ☐ Yes Division of Vital After this certification, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural
2 Accident 5 Pending investigation aspital ...
4 hours after dea...
-ral Director: Aftr м 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DSIDIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byuks NO 4
32 negistrar's Signature
06 W Redward St, 3rd Floor Boltimus MD 405 31. Date filed (Month, Day, Year) Monade State 2006 Registrar

			1 - For State Registrar		State of	Marylan	d / Dep		nt of H	lealth a	and N	Mental Hyg	niene -	16	036	5
	Dhysia		1. Decedent's Name (F	irst, Middle,	Last)							2. Date of Dea Month	ath Day	Year	3. Time of	Death
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	Examir		4a. Facility Name (If no			iber)		4b. City,	Town, or	Location	of Death		4c. Count	of Death	1	
1			3024 Wood	side A	venue				Park	ville	е			Balt:	imore	
	Funeral		5. Social Security Num	ber 6		7. Age (In yrs.) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birti (Month, Da)	h /, Year)	9. Birth Col	nplace (State of untry)	r Foreign
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336	hours after tural', or ite	by	3℃ Widowed 4 [If Yes, Give	3		1 🗆 Yes	2 🔀 No	Specify:			Specif	y: Wh	ite	
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	e filed within at Hygiene. I other than vent, the Ma	Bec	17. Father's Name (Fin	st, Middle, La	st)					18. Mothe	er's Name	e (First, Middle,				
<u>a</u>	Aental Aental rked tic ev	To	Irvin Mil	ler						F	Bessi	ie Mengl	e			
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	alth a		Karen L. H	ryer/I	Daughter		3024	Wood	side	Aver	1110	Parkvil	lo. Mir	21	234	
Baltimore,	of Heal	1 3	20a. Method of Disposi	ition			lace of Dispo	osition (Nar	ne of			Date	20c. Location			
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	/Medical		disease or condition resulting in death)	4		or as a consequ		ے ک	صب		CCI	Den	7		1 000	
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Вох	eath certific attending p	Physiclan/Med	23b. Was decedent pre		23c. If yes, outc	ome of pregnal		∃Ectopic pr	eanancy				23d. Da	te of deliv	/егу	
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	98 P. 69	by	Part II. Other significar	nt conditions	contributing to dea	ath but not resu	ilting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use cont	ribute to	the cause of de	ath?
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Records,	e taw r has be je 2 sh	Completed										24a. Was a		Were aut	opsy findings a	vailable
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Vital	ding Physician: The h.h. h. After this certificate ha funeral director, page	Bec	25. Was case referred	to medical						26. Place	of Death	Check only or		103	20110	
†	Physician: this certificanal director, i	To	examiner? 1 🗆 Yes 2 🗹 No		Hospital: 1 🗆 In	patient 2 🗆 E	ER/Outpatier	nt 3 🗆 DO	A Othe	-		me 5 Reside		er (Speci	fv)	
n of	ng Ph Iter th		27. Manner of Death	Pending	28a. Date of (Month	Injury Day Year)	28b. Time o	f 2	8c. Injury Work			28d. Describe ho				
Ö	Attending r death. ector: After y the fune	atte	2 Accident	investigati	on	, ==, :==,	,=,,	M		es 2 🗆 1	No					
Division	after death after death Director: I in by the	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	d 286. Place of	of Injury - At hor g, etc. (Specify	me, farm, str	eet, factory	, office			28f. Location (Si City or Town	reet and Numb	er or Rur	al Route Numb	er,
	rs aft el Di ed ir	Cer		,												
	t hour une sly fil	cal	29a. Certifier 1	Certifying R	hysician: To the bandner. On the bas	est of my know	viedge, deati	n occurred a	at the time	e, date and	d place, a	and due to the ca	ause(s) and ma	inner as	stated.	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical			and manne	or stated.					- Occurn					
	To Too	**	29b. Signature and title	ot certifier				29c	License			2	9d. Date signe	d (Month,	Day, Year)	
		- 1		R)	\				D,	446	O4.		Februa	ry 9	, 2006	
	in		30. Name and address	rerson who	o competed cause	of death (Item	23а) (Туре,	Print)	_	ione E						
	10		SUICHUE	- Sitt	2 8	10214	10FOR	o Rd	<u>.</u> S	une E	Te.	Bren	nove l	NO	5(53)	t
,	Sta		31. Date filed (Month, E	yay, Year)	32 Re	gistrar's Signat	ure	200								
	Registr	ar	FEF	3092	006	in At	A PA	ALL								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician egory Month incent 5:30 AM 28. /Medical JANUARY 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Joseph Medical Center Saint Towson 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**X**M 2□ F 219-52-548 Yrs. Director we Usual Residence of Decedent with the Maryland 10a State 10h County or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 X es 2 No Completed by Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other treumatic event, the Medical Examinar must be ISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes Yes, Give Year or Dates: No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry VI romenta bndary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Pages 1 and 2 should be i and Mental i 2 narlie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health ette lurner Date MAKE 20a. Method of Disposition 20b. Place of Disposition (Name of Depertment of h Important: If Ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State MEMORIA L 4 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) COLENT 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of spin shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC PANCREATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ettending physicien and for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death ed by the e 5 Other (specify) P.O. 9☐ Unknown 9 Unknown sete has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 2 INO 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No this certificete has 1 Yes Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.
To the Funerel Director: After th. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0/128 2006 D 26594 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, TOWSON, MARYLAND 21204 7601 CHIMM. M. OSLER 31. Date filed (Month, Day, Year) FEB 0 9 2006 32. Registrar's Gignature State Registrar

			For		of Marylar						-		egible.		27-08 48-4
			1 - For State Registrar			Ce	rtificate	e of L	Death			eg. No.	106	035	53
	Physici	an	Decedent's Name (First, Mid								Date of Dea Month	Day	Year	3. Time of	
	/Medic	al	Hazel Willard 4a. Facility Name (If not institute		number)		4b Ciby	Tours or	Location of	of Dooth	2-4-200		County of Death	6:55	P ^M
	Examin	ier	Millenium Heal		· ·	tation	Glen			Di Death					
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under	1 Year	If Under		8. Date of Birth (Month, Day		Anne Anne Anne Anne Anne Anne Anne Anne	cundel place (State o intry)	or Foreign
	Director		217-10-7782	1 ☐ M 2 🕅 F	90	Yrs.	Months	Days	Hours	Min.	6-20-1	915	MD	intry)	
	and		Usual Residence of Decedent 10a, State 10b, Coun	ty	10c. C	ity, Town or Lo	cation							10d. Inside C	itv Limits
	Maryl f sho	to	MD Anne	Arundel	G1	len Bur	nie							1 🗌 Yes	2 ⊠ No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Cou	intry?	
	23a c	ai D	6506 Home Wate	r Way #3	02			21	.060			U	.S.A.		
	tems	uner	11. Marital Status		ecedent Ever in L Forces?	J.S. 13.	Was Deced If Yes, spec	ent of Hi	ispanic Ori n, Mexican	gin? (Spo	ecify Yes or No- Rican, etc.)	14	Race - Amer Black, White		
36	rs afte		1 Never Married 2 Married	. If Yes,	s 21(1) No Give Dates:		1 □ Yes 2	ZXNo	Specify:			S	Specify: Wh	nite	
9	within 72 hours after death with the Maryland sne. than "natural", or items 23a or 28a-1 show ha Madigal Examinar must be malified at	Completed by	15. Decede	ent's Education		16a. Dece	dent's Usua	l Occupa	ation			16b. Kind	d of Business/Ir	ndustry	
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7	led willygien her th	Con	12	. (4)			Seams	tres		de Name	(Fire A. A. Sindada		tile		
and	I be fi	Be	17. Father's Name (First, Middle William Zembo								o <i>(First, Middl</i> e, Le Leisu		umame)		
Maryland 21215-0036	should nd Me mark matic	ပို	19a. Informant's Name/Relation			19b. Mailir	ng Address	(Street a			I Route Number		Town, State, Zi	p Code)	
	alth a		Mrs. Marion B	rooks / D	aughter	6506	Home	Wat	er Wa	y #3	02; Gle	n Bu	rnie. M	D 2106	0
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b.	Place of Dispo cemetery, crei							ation - City or T		
Ĕ	Pages ment of lant: If it		'4 Donation 5 Other		Hi	llcres					2006		berland		
Ball	Departiment Departiment Important Im		21. Sign ture of Fundal Service	Licensee	le mois						gleton en Burn				
	402.44		23a. Part1. Enter the disease,	or complications that	120	_						-	MD 2106	Approximat	е
	Democratic		Immediate Cause (Final	st only one cause of	n each line.		1	11-			,	,		Interval Bet Onset and I	ween
	Priysician /Medical		disease or condition resulting in death)	a	to (or as a conse	quence of):	14	luy	uci	0		7			
	Examiner		Sequentially list conditions.	ь	houic	_ CU	Mru	cle	٥	Kel	lucry	k	reca	~	
	Si 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	V Due t	to (or as a consec	quence of):			(Pe	/ [χ.				
1	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a consec	quence of):									
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gox	ath ce ttendii	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/hths?	1 Live	outcome of pregne birth 2 Peta	al death 3	Ectopic pre					23	d. Date of deliv	•	Year
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۹.	that the	y Ph	Part II. Other significent condi	tions contributing to	death but not res	sulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	bacco use	contribute to	he cause of d	leath?
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/ita	Attending Physician: The law r death. ector: After this certificate has l by the funeral director, page 2 s	Be (25. Was case referred to medic examiner?					104	- 2	of Oeath	(Check only or	10)			
ot	Physi this c	- To	1 Yes 2 No		☐ Inpatient 2 ☐	ER/Outpatier			الاستف		me 5 Residence 128d. Describe he			fy)	
on	ding th. : After	tion	Natural 5 Pend	ling (Mi	te of Injury onth, Day Year)	Injury	м	3c. Injury Work 1 🔲 `	ເ?ົ່ Yes 2 🔲 I		200. 2000. 2011	ove injury	00001100		
Division of Vital Records,	Attender dea ector	Certification;	3 Suicide 6 Coul	d not be 28e. Pla	ice of Injury - At h	nome, farm, str	eet, factory	, office			28f. Location (S. City or Town		Number or Rur	al Route Num	ber,
ā	rs afte al Dir led in	Cert	T I TOMICOS	Dui	iding, etc. (Speci							i, Olale)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medica	ing Physicien: To t al Examiner: On the	basis of examina	owledge, death ation and/or in:	n occurred a vestigation,	at the tim in my op	ie, date an oinion, dea	d place, a	and due to the c ed at the time, d	ause(s) ai ate and p	nd manner as s lace, and due t	stated. o the cause(s	.)
	To the within 2 To the Complet	Med	29b. Signature and title of certif		anner stated.		29c.	License	number		2	9d. Date	signed (Month,	Day, Year)	
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	12		30. Name and address of person				Print)	D !		4		-	-/		
			600 Field	Sely A	ne S	uele.	2	31	7	Ano	april	4 7	up 2	190	1
	Sta Registr		31. Date filed (Month, Day, Yea	32	. Registrar's Sign	ature /	المالية			•					
	riegistr	ш	FEBO	9 2006	MARI 1	U A									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03654 1 - State Registrar Day The Year 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIOLA FORD esmany 3.15 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 31 | Year | 1922 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 □ F 413-52-0582 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Sykesville Md Carroll 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6313 Georgetown Blvd. 21784 Apt C USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify: Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) seamstress clothing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Clyde Bowman Trula Gladys Massingill 19a. Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Murial 2 Cremation 3 PRemoval from State 2/8/06 Mountain Home, TNMountain Home Nat: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ▶ Paige Haight P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theunong onments acquired Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dionino nathr anteri mari 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🕱 Ńo reare 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ⊠No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 (Nnpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Physician /Medical Examiner thet the death certificate be executed Records, P.O. Box 68760 Hospitel or Attending Physicien: funeral director. death. within 24 hours at To the Funerel D completely filled i To the

attending p signed by the a d be detached f certificate has been s rector, page 2 should filled in

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State Registrar

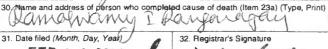
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31. Date filed (Month, Day, Year) FEB 0 9 2006

Damomani

29b. Signature and title of certifier

29a. Certifier



15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nerthwest Homilal

29d. Date signed (Month, Day, Year) February 44 2006

			For 1 = State Registrar	State o	f Marylar				ealth a	and M	lental Hy	giene,	006	03655
	83		Decedent's Name (First, Middle,	Last)							2. Date of De			3. Time of Death
	Physici /Medic	_	ANNA GABOR								Februa		2006	1:30 a M
	Examin	_	4a. Facility Name (If not institution, g		nber)		4b. City,	Town, or	Location of	of Death			ounty of Dea	
			Stella Maris Hos					owson		0411-0			ltimo	
Š _V	Funeral Director	y 1	011-03-7365	.Sex 1□M 2□F	7. Age (In yrs. 92	last birthday) Yrs.	Months	n 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Nov • 7	ay, Year)		nthplace (State or Foreign country) ingary
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show avent. The Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1XXvever Married 2 Married	Armed Fo 1 ☐ Yes ff Yes, Giv	2 X No 'e		Was Dece f Yes, spe	cify Cuba	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, Wh	•
9	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or D	ates:	16a. Deced	lant'e Hen	al Occups	tion				Wr of Busines:	nite
Baltimore, Maryland 21215-0036	nin 72 n "na Nedic	Completed	(Specify only highest	grade completed)	407.51)	(Give	kind of wo	nk done o se retired	luring most)	of work	ng	100. Kilic	i di Daziliazi	smoustry
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<u>X</u>	as 1 and 2 should b of Health and Ments I Itsm 27 Is marked r other traumatic s	은	William Gabor						Lill	ian	(unkno	wn)		
ar	2 sho		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a	nd Numbe		l Route Numb	•		Zip Code)
esî	l and lealth im 27 her tr		Marguerite Lilli	an Penn	120b	_			Road		urel, I			20723
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g	permit. Pages Department of Important: If I any injury or o		163	/	M00770						lome, P		arri a sa si	20707
(A)		Ī	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	emplications that c ly one cause on e		J.					Laure. or respiratory a		Lyland	Approximate fnterval Between Onset and Death
9760,	Centificate be executed his principle. [Medical publication and publication and publication as the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, 1 and the cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b Due to (or as a consec	quence of):								
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as, T	gned be de	ρ	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying o	ause give	n in Part I.		1			to the cause of death?
Vital Records,	The law requir ate hes been si page 2 should I	Completed									24a. Was auto perfo 1 Yes	psy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of
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	di S	To	1 Yes 2X No	Hospital: 1 🗆 I	npatient 2	ER/Outpatien	t 3□ D0	Othe Othe	r. 4 □ Nu	rsing Hor	ne 5□Resi	dence 6	Other (Spe	ecify) HOSPICE
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DIVISION	in Diffe	Certification:	3 Suicide 6 Could not 4 Homicide determine	280. Place	of fn j ury - At h ng, etc. <i>(Speci</i>	ome, farm, stre fy)	eet, factor	y, office			28f. Location (City or To	Street and I wn, State)	Number or F	Rural Route Number,
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•	1			12					143	72.	(2/7/	106
	19		30. Name and address of person wh					_		-				
10	* ***	10	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)		DULANE egistrar's Signa		EY RI). T	TMONI	UM,	MD 210	93		
	Sta Registr		FEB 0 9 2			the ela	ente							

			For State Registrar	State	of Marylar	_	artment of rtificate o		and Me	-	iene	06	036	56
			1. Decedent's Name (First, Middl	e, Last)						2. Date of Deat Month		Year	3. Time o	of Death
	Physici /Medic		Naomi Ruth Ge	ensiak						Februar		2006	4:00	AM M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town	, or Location o	of Death		4c. Co	unty of Death		
			Sligo Creek N					a Park				nce Ge		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day,			place (State intry)	
ш	Director		579-34-4959 Usual Residence of Decedent	Λ	77	113.				Apr 22,	1928	Wash	ingtor	DC -
	/land		10a. State 10b. County		1,0c. Ci	ty, Town or Lo	cation						10d. Inside C	City Limits
	Many F-f sh fied	tor	MD Princ	e George	s	Co11	ege Parl	k					1 🗌 Yes	2 No
	r 28g	Director	10e. Street and Number				10f. Zip Cod	e		1	0g. Citizen	of What Cou	intry?	
	death with the Maryland ims 23a or 28a-f show	aiD	9014 Rhode Isl	and Aveni	ie #706			20740				USA		
	ams	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of	of Hispanic Original	gin? (Spec	rify Yes or No-		Race - Amer Black, White		
õ	or it		1 Never Married 2 Mar	ried 1 Tyes	2 XNo Sive		1 □ Yes 2 🔽 N					ecify: wh:		
2-003e	ural'	d by	3 XWidowed 4 □ Divorced		Dates:	16a Dana	donte Herel On							1
ဂ်	n 72 r "nat	Completed	(Specify only highe			(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most	t of working	g	IDD. KING	of Business/Ir	idustry	unk
7	withi ene. than	шс	Elementary/Secondary (0-12)		(1-4or 5+)		sekeepi							
7 5	ould be filed within 72 hours after Mental Hygiene. arked other then "natural", or Ita attic avant, the Medical Exprend	a	17. Father's Name (First, Middle,			1100	вексері		r's Name	(First, Middle, M	Maiden Sui	name)		
and	ld be ental kad kad ic av	To B	Raymond Oliver	r Gibson				Vic	ola M	ay Fobe	r			
	shou nd M mar umat	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Stre	et and Numbe	r or Rurai	Route Number	City or To	wn, State, Zi	p Code)	
M	aith a 27 is		Sligo Creek Nur	sing & R	Ehab Ctr	752	5 Carro	11 Aver	nue Ta	akoma P	ark,	MD 209	12	
a e	of Hear		20a. Method of Disposition		20b. l	Place of Dispo	sition (Name of	place)	Da	ite	20c. Locati	on - City or T	own, State	
Ĕ	Page nent c int; if		1 ☐ Burial 2 ☐ Cremation '4 ☑ Donation 5 ☐ Other (S		n State									
рашно	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at QDCs.		21. Signature of Funeral Service Ronald	S. Wade	Directo		Name and Ad tate Ana altimore	dress of Facility B	oard 21201		Balt:	imore	Street	
П			23a. Part 1 Enter the disease, o shock or heart failure. List	r complications tha	t caused the dear						est,		Approxima Interval Be	te tween
	Pnysician		Immediate Cause (Final	only one cause on	I Culo	m	YOCH	Soll N	A	INFA	m.	Lenia	Onset and	Death
	/Medical		disease or condition resulting in death)	a. Due t	o (or as a consec	quence of): /	7000	1010	1	11110	1	1001		
	Examiner		O			-	1							
n.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):								
	nd nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С										
Ď,	e exe		resulting in death) Last	Due to	o (or as a consec	quence of):								
0/8	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	dical		d										
2	ertific ding p	Me	IF FEMALE:	220 If you	utaama of proop	2001						-		
ž Q	ath c	hyslcian/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregn	aldeath 3[Ectopic pregna				23d.	Date of delive Month	,	Year
	the de y the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk	gnant at time of one of the control	death 5L	Other (specify,							
7.	that the	۵.	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use	contribute to	the cause of	death?
Š,	requires that been signed b hould be deta	d by								1 □ Ye	s 2 N	o 3□Pro	bably 4	Unknown
cords	requ been shoul	ete								24a. Was a	2	4b. Were aut	aneu findinge	available
ě	2 3 3	ompleted								autops	y	prior to co death?	ompletion of	cause of
<u></u>	n: Th licate r, pag	O	05 11/-						4.504		2€ No	1 🗆 Yes	2 🗷 No	
VIIai	Physician: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred to medica examiner?	Hospital:	☐Inpatient 2☐	ER/Outpatier	20004	Othon	_	(Check only on e 5 ☐ Reside		Othor /Cros	····	
ō	> 0 0	 	27. Manner of Death	28a. Dat	e of Injury	28b. Time o	f 28c. lr	njury at		8d. Describe ho			(9)	
0	th. ; Afte	tlor	1 Natural 5 Pendii 2 Accident invest	ng (Mo	onth, Day Year)	Injury		Vork? □Yes 2□I	No					
UNISION	Attending r death. actor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could	nined 200. Fla	ce of Injury - At h	nome, farm, str	reet, factory, offi	ce	28	Bf. Location (St.		umber or Rur	al Route Nur	nber.
5	al or	Certification:	4 Homicide	bui	lding, etc. (Speci	ITY)				City or Towr	i, State)			
	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Diractor; After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To t Examiner: On the	he best of my known basis of examination	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date and y opinion, deat	d place, ar th occurred	nd due to the ca	ause(s) and ate and pla	d manner as a	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifie				29c. Lic	ense number		2	9d. Date si	gned (Month,	Day, Year)	
	F S F Ö		100	9114	416	7	D	474	71		\mathcal{A}	1214	26	
			30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)		/ 1			0 5	0	
			yehey, 5) No	Registrar's Sign	il	5 h	30 C	nee	KY	1Vr	Sing	tron	ne.
	Sta Registr		31. Date filed (Month Day, Year FEB 0 9	2006	Bush of	The state of the s	- 10 miles	V						

06-00893 Theresa Hough

				Department of Health and M	Mental Hygier	9 006 03657
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N	
	Physici		Theresa Hough			04, 2006 21:36 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Harbor Hospital Center	Baltimore		NA
	Funeral Director		210/00015	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Mgnth, Day, Yea	9. Birthplace (State or Foreign Abounty) 163 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	Mary a-feh	ţċ	Maryland N/A Ba	Itimore.		1 X es 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	• 23a	rai	2313 Slaney Ave	2/230	- 4 V N	USA
10	fter de	Funerai	11. Marital Status 12. Wa≴ Decedent Ever in U.S. Armied Forces? 1 Never Married 2 Married 1. Wa≴ Decedent Ever in U.S. Armied Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itame 23s or 28s-f ehow then "natural" be notitled at	ξ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black
5-0	"natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ting 16b.	Kind of Business/Industry
121	within ene. then	Jung	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Domostic
	be filed within 72 hours after death with the Marylar nta! Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene. Indi Hygiene.	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Sumame)
/lar	should be nd Mental marked o matic eve	TO B	Leslie Hough Jr.	Joyce	Linda	i Butler
Maryland	she mud	3	19a. Informant's Name/Relationship (Type, 1) daughter 19b	. Mailing Address (Street and Number or Rur	al Route Number, City	y or Town, State, Zip Code)
	s 1 and 2 f Health item 27 I				Date 20c.	Location - City or Town, State
ē	00		1 🗷 Burial 2 □ Cremation 3 □ Removal from State cemates 4 □ Donation 5 □ Other (Specify)	ry, crematory or other place)	2006 LA	inc downe Md
Baltimore,	permit. Peg Department Importent: I any Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		Associate 1 Mar
8	89 = 9		Joseph L. Russ	2222 W.North AJ	e. Baito	Ma:21216
			23a. Part Enter the disease, or complications that caused the death. Do shock, or heart fallure. List only one cause on each line.			Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)	TE CARDIOVASCUE	Now DISE	からで
	Examiner					
	D ===	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		
٧	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	of):	• • • • • • • • • • • • • • • • • • • •	
8760,	cate be executed physicien and the burial-transit	dicai E	L _d			
•		Medi	IS STANKS			
Вох	death certifii e attending j id for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death			23d. Date of delivery Month Day Year
0.	at the dea by the a tached for	Physician/Me	1 Ves 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Day Toll
<u>α</u>	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rds	w requires been sign should be				1 🗆 Yes	2 No 3 Probably 4 Unknown
of Vital Records,	G 25 C	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E					performed?	
ΖĬ	5 8 9 P	o Be	25. Was case referred to medical examiner? Y□ Yes 2□ No Hospital: 1 □ Inpatient 2 □ ER/Ou	Othor	h (Check only one)	C = 0+ (0 t)
o t		H .	27. Manger of Death 28a. Date of Injury 28b.	Firme of njury 28c. Injury at Work?	ome 5 Residence 28d. Describe how in	
sior	Attending death. ctor: After y the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	if or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospita 14 hours Funerel tely filled	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.), death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			Mayour Me Shell rus	O.C.M.E.	Fe	ebrua 05 2006
	1		30. Name and ad ress of person who completed cause of death (Item 23a)	(Type, Print)		
	Sta	to	21 Date file (Month Day Veer) 22 Pegistraria Signature	111 Penn Street, Balt	imore, Mar	cyland 21201
	Registr		FEB 0 9 2006	parte		

			1 - For State Registrar	State of M	aryland / [Departme <i>Certifica</i>	nt of H	ealth a Death	nd Mental		ene () ()	6	03658
ľ			Decedent's Name (First, Middle, Last,			001111100			2. Date	of Death			3. Time of Death
	Physici /Medio		Mary Lois O'Kan	e Howard					Febr	uary	^{Day} , 200)6°	5:17a. м
	Examir		4a. Facility Name (If not institution, give Route 340 Eastbou	street and number, ind at St			, Town, or Jeffe	Location of Prson	Death		4c. County of		k
	Funeral Director		5. Social Security Number 6. Sec. 212-68-1867	7. A	ge (In yrs. last bir 49	Yrs. If Und Months	or 1 Year Days	If Under 2 Hours	Min. (Mont	of Birth h, Day, Y	ear) 1956 (9. Birthp Cour Dkla	lace (State or Foreign try) noma
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location						1	Od. Inside City Limits
	f sho	ō	MD Frederic	k		erick						,	1 Tyyes 2 □ No
	r 28a	Director	10e. Street and Number		TIEU		ip Code			10g	. Citizen of W	hat Cour	ntry?
	th with		213 Center Stree	t		2	1701				US	SA	
	dea r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Dec	edent of His	spanic Orig	in? (Specify Yes of Puerto Rican, etc.	or No-	14. Race		ean Indian,
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2♥☐ If Yes, Give Year or Dates:	No	1 ☐ Yes		Specify:		•	Specify:		
8	hour	ed b	15. Decedent's Edu		16a.	Decedent's Us	ual Occupa	tion		16	b. Kind of Bus		
21215-0036	hin 72 In "in	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or		(Give kind of w life. DO NOT	rork done d	uring most	of working	-			
2	ed wit	Con	12th	l yr.		eal Est	ate A				Realty		
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last)	177					's Name (First, Mi)	
3	hould d Mer marke matic	2	Brooke Grayson O 19a. Informant's Name/Relationship (Ty			Mailing Addre	- (Street a		elle Loi			· · · · · · · · · · · · · · · · · · ·	0-4-1
<u>⊠</u>	Ith an		Charles Herbert Ho			-			or Rural Route N				
ē,	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any figury or other traumatic avant, it a Medical Exercitar marker notified at ance.		20a. Method of Disposition		20b. Place of	Disposition (N.	ame of		Date	_	c. Location - C		
Ë	Pege nent o int: If		1 ⊠Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	emoval from State		Cemete.		. 1	/10/2006	Bı	urtons	/ille	∍, MD
Baltimore,	permit. Depertin Imports any Inju		21. Signature > Funeral Service License	1					Donalds				e, P.A.
_	90F = 9		Now My		100773				nue, Lau			707	
	Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as	l ul tijl	e I	rju		arquae or respirate	ory arrest			Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· .	a consequence of	,							
P.O. Box 6	that the death certified by the attending problem detached for use as	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (s					23d. Date Mont		ory Day Year
	tuires that n signed b	d by Phys	Part II. Other significant conditions con	tributing to death t	out not resulting in	the underlying	cause give	n in Part I.		Did tobad			e cause of death?
Division of Vital Records,	he law requir e has been si ige 2 should	Completed			P-81					Was an autopsy performed	pr	ere autopor to conseth?	osy findings available appletion of cause of
ta		a)	25. Was case referred to medical					26 Place	of Death (Check of		No 1	Yes	2 No
<u>=</u>		To B	examiner? M☐ Yes 2☐ No	ospital:	ent 2 ER/Out	tpatient 3 🗆 🛭	Othe				e 6XOther	(Specify	At scene
0	ng Pt		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	ry 28b. T	ime of	28c. Injury Work	at ?	28d. Desc		injury occurre		
Sio	tandi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 □ Could not be		6 5	II AM	1 🗆 Y	es 2DXN	1 00.		an s		
\leq	or At after d Direct in by	Certification;	4 Homicide determined		ury - At home, fai c. (Specify)				28f. Locati City o	ion (Stree r Town, S		or Rura	Route Number,
_	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge	death occurre	1 Way	e. date and	place, and due to	the caus	Rd Je	Mer as st	ison MD
	ne Ho	Medical	(Check only 2 Medical Examilione)	ner: On the basis of and manner st	f examination and	Vor investigation	n, in my op	inion, death	occurred at the t	ime, date	and place, ar	d due to	the cause(s)
	withir To the	M	29b. Signature and title of certifier	.1		2	c. License	number		29d.	Date signed	(Month, I	Day, Year)
)	7		Larde	Hallai	rud		OCM			Fe	bruary	5,	2006
1	00		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type, Print) 1	l Per	ın Str	ceet Bal	Ltimo	ore, Ma	ryla	nd 21201
1		٠,	31. Date filed (Month, Day, Year)	32. Regi	ar's Signature								
	Sta Registr		FFB 0 9	2006	all the same	S. Son	de						

Z	
Baltimore,	
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Box 68760,	
P.O.	
Records,	
Vital	
ion of	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 2006 **Physician** Month Fe bruary 2:04 Lois M. Harris /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BA HOSPITA SINAI N/A timore If Under 24 Hrs. 8. Date of Birth Hours Min. Feb 9, 1932 If Under 1 Year 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 ☐ M 2**X**☐ F 73 238-44-7590 Yrs. Director North Carolina Usual Residence of Decedent the Maryland 10a State r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Completed by Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other then "natural", or items 23a or other traumatic event. It a MacIdal Examination to 3026 Mayfield Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other then "natural" or iter Black, White, etc. 1 Never Married 2 Married vland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nursing Assistant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Artis Winston Lureatha Peten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny Injury or other trau once. Evelyn Harris, Dauchter 3026 Mayfield Avenue Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 02/09/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARdi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERIENSION Completed 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death. To the Funeral Director: After this certificate has been is completely filled in by the funeral director, page 2 should Diabe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 22 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 X ER/Outpatient Certification: To 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of cortified 29c. License number 29d. Date signed (Month, Day, Year) D0054558 Jhysician February n completed cause of death (Item 23a) (Type, Print) mo 2401 W. Belvedere Ave Baltimore, mo 21215 BURKE REDERIL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

9 2006

FEB 0

Raymond William Jedlicka Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00953 State of Maryland / Department of Health and Mental Hygiene crn 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** KAYMOND 6:42 A M February 07, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Johns Hopkins Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 3 216-42-4320 Yrs. Director July 12 1942 MARY (AN) Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show and Mental Hygiene. Is marked other than "nstural", or Items 23s or 28s-f shov sumatic svent, the Medical Examinar must be motified at MARYAND 1 Yes 2 No Director Altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3415 E 2122 U.S. Funeral HUENUC recourt 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married I □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SteeL StCELWORKCE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew 2 TMMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: If itsm 27 Is eny Injury or other trau once. Jedlicka - WIFC 3415 E. FAIRMOUNT 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenment Cremarory Feb 11, 2006 22. Name and Address of Facility
305CFLN ZANNINO 21. Signature of Funeral Service Licensee 3635 CONKLING Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) contact governot wound of head **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the eld be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown been si 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No certificate has birector, page 2 s 24a. Was an autopsy performed? (es 2 \sum No 1 Yes director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending Investigation subject shot selt within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu -7-06 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number. City or Dawn, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Control of the date of the d 29a. Certifier To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 08, 2006 e and address of person who completed cause of death (Item 23a) (Type, Print) ATRIGA

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 09

2006

K ~ 111 Penn Street, Baltimore, Maryland 21201

Tol

32. Regultrar's Signature

			1 - For State Registrar	State of Maryla	and / Dep		f Health and		3	03661
	Physic	ian	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give	Yis M street and number) ,	1	Jablon 4b. City, Tow	SKi. n, or Location of De	Februa eath	4c. County of I	06 7.40 A "
	LAdiiii	ICI	Franklin Sawar	2 Hospital	/	Rose	edale		Bn /+	imano
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Ye	ear If Under 24 h	irs. 8. Date of Birtl	h 9.	Birthplace (State or Foreign Country)
25	Director		439-18-4115 Usual Residence of Decedent	85	Yrs.			Dec. 5,	T	Ouisiana
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	the Marylar 28a-f show	ctor	Maryland Balti	more			Dunda	1k		1 ☐ Yes ŽINo
	or 28	Dire	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of Wha	it Country?
	72 hours after death with the Maryland natural', or items 23a or 28a-f show altest Exacult without be rectified at	Funeral Director	7423 St. Patricia		11.0		2122		United	
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	10.5.	If Yes, specify C	of Hispanic Origin? Suban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	Black, \	A <i>m</i> erican Indian, White, etc.
036	al', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:		Specify:	White
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Oc	cupation one during most of	working	16b. Kind of Busin	ess/Industry
121	ne. han	m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)			
d 21	Hygie Hygie ther i		5 Years 17. Father's Name (First, Middle, Last)			Hous	sewife 18. Mother's N	Name (First, Middle,		Home
lan	ld be ental ked o	To Be	John Lasserre					lina Brack	,	
Maryland	and M and M a mar	-	19a. Informant's Name/Relationship (Ty					Rural Route Numbe		te, Zip Code)
	and 2 ealth n 27 i		Doris A. Jones	(Daughter)			ffe Road			21221
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event; its Medical Executarization to stiffied at any injury or other traumatic event; its Medical Executarization to souther any once.		20a. Method of Disposition		cemetery, creations	osition (Name of matory or other	place)	Date	20c. Location - Cit	y or Town, State
Ë	rtmen rtmen rtant: njury	-	4 Donation 5 Other (Specify)	1 00			Cem. 2/9	2006	Possvi	lle, Maryland
Ba	Depar impor any ir		21. ture of Funeral Service Licens	Clu	4 7	Duda-Ruo 1922 Wis	e Ave. 1	1 Home of Dundalk, M	Maryland	Inc. 21222
			23a. Part1. Enter the disease, or complesheet, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not en	ter the mode of	dying, such as card	liac or respiratory arr	rest,	Approximate Interval Between Onset and Death
40	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MINION		Ege	11/1a			
	Examiner		f.	Due to (or as a cons	sequence or):	Anto.	n. Di	Sease		
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760,	be ex ician a burial	al E	Toolsting in doubt, East	Due to (or as a cons	sequence of):					
687	tificate og physi as the			1.						000000
Box (cer ndir use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre-					23d. Date of	f delivery
	res that the death igned by the atler be detached for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F		Ect <i>o</i> pic pregna Other (specify			Month	Day Year
P.0	at the	hys	9 🗆 Unknown	9□ Unknown						
	ires th signed d be de	þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	inderlying cause	given in Part I.			te to the cause of death?
Records,	w requir been si should	Completed by	P. IM	1 harden	(11)			- 1×1		Probably 4 Unknown
Rec	has ge 2 s	ig ii	1 all alland	Typer Terr	510 h			24a. Was a autops perfor	sy prior	e autopsy findings available to completion of cause of h?
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical	24 tall	re		00 Diago of F	1 Tes	20 No 1 🗆	Yes 2□ No
N.	Physician: r this certifica ral director, i	To B	examiner?	lospital: 1 Inpatient 2	□ ER/Outpatier	nt 3 DOA	Other	Death (Check only or Home 5 Aeside		Speciful
J of	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,		f 28c. Ir	njury at Work?	1	ow injury occurred	opocity)
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Division	f or Attendiater death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office	се	28f. Location (Si City or Town	treet and Number o n, State)	r Rural Route Number,
	pitel ours a erai E		29a Certifier (V Certifying Phys	lician: To the best of my k	er and a day of the	t construction of the Park	The second second second		vicinia vicinia di Pari	
	To the Hospite within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examinations)	ner: On the basis of exam and manner stated.	ination and/or in	vestigation, in m	y opinion, death of	ccurred at the time, d	ate and place, and	due to the cause(s)
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	0		29c. Lice	ense number	2	9d. Date signed (M	fonth, Day, Year)
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1	20 °		30. Name and addre is of person who co	mpleted cause of deat (I	tem 23a) (Type,	Print)	W. 0		. 1	MINIO
	/		31. Date filed (Month, Day, Year)	32. Ke gistrar's Sig	41 400	00 trai	nklin sy	quate Dr	rue Bat	T11021237
*	Sta Registr			106 32. Goo gistrar's Sig	A A	garde.	ı			/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Z 3. Time of Death Helquay Jordan **Physician** John 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TIMORE 7. Age (In yrl. last birthday)
Yrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f show yent, the Wedical Evanture must be notified at 1 XYes 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 2 No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, (First, Middle, Last) is marked of ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Pages 1 and 2. Department of Health ar Important: If item 27 is Murial 2 ☐ Cremation 3XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any ir d. Balto MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final disease or condition **Physician** Hore Thou resulting in death) /Medical weeks Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No be detached 9□ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ØUnknown should 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy certificate 2. No 1 Tyes the Hospital or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Dther: 1 ☐ Yes 2 No 4 Nursing Home 5 Hesidence 6 Other (Specify)
28d. escribe how injury occurred P 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
February 3 2006 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a), Type, Print)

Baltimal Hall 31. Date filed (Month, I Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Man		artment of I			iene	06 (03663
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	Examir	ner	4a. Facility Name (If not institution, give			1 11	or Location of Death		4c. Coun	ty of Death	
		Н	132 N. 132 the 5. Social Security Number 6. Se	St. 7. Age //	n yrs. last birthday)	If Under 1 Year	more If Under 24 Hrs.	8. Date of Birth	n	9 Birtholi	ace (State or Foreign
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Jo /	cian: ertifica	Be	25. Was case referred to medical examiner?				26. Place of Death				
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77	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		(Check only 2 Medical Exami	sician: To the best of m	y knawladge death	occurred at the til	me, date and place, s	and due to the ca	use(s) and m	and due to the	ted.
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	T William	8	San Signatura de la constante	1	^		62(1	29	- 10	ed (Month, Da	ay, rear)
	3		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type F	_	241	-	2/0/	UQ	
	ン		JOHN F. JEWZ	JMD 30	01 S. t	FANOUE	RST B	ALTIM	ORF.	no a	21225
	Sta		31. Date filed (Month, Day, Year) FEB 0 9 2006	32. Registrar's	Signature	20	.,,				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item#19b, perFIL Inf, 0852, 2/14/06 TT

State of Maryland Department of Health and Mental Hygiene 10.7

Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2005 February 2, Violet R. Jones 5:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care Severna Park Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 20 F 84 Yrs. Director 215-72-6327 6/20/1921 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "netural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23a or 28a-f shor treumatic event, the Medical Examiner must be notfilled at MXYes 2 □ No MD Calvert Director Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 2616 Apple Way United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: Specifywhite Be Completed by ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph C. Dean Ruth E. Fowble ဥ 195 Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2026 Apple Way Dunkirk, MD 20754 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tree once. Charles Jones (son) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Fort Lincoln Cemetery 2/7/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Acute Renal Pailure
Due to (or as a consequence of): Examiner Physician/Medical Examine Dehydration bue to (or as a conseque ed by the attending physician end detached for use as the burial-transit Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a conseque Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause 1 Yes 2 Who 1 TYSS PLING eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Abatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D6 1829 30. Nam and ddress of person who completed cause of death (Item 23a) (Type, Print) MD, 2108 D. Donuto Drive LEE- LLACER 27NALDE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician JENKINS** January 2ĺ 2006 02:39 a M JANIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HARFORD CO HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M XXF Yrs. 71 Director 244-06-7661 22 1934 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes XXNo Director MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21001 U.S.A. 439 EDMUND STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A HOMEMAKER unknown treumatic event, should be fit the and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 ie marked teny injury or other treumatic ever spage. ဂ DRUCILLA LASSITER unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Harford Square Dr., Edgewood, Md., 21040 Nichole Williams/Great Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoxal from State 4 Donation 5 Other (Specify) 01-31-06 BALTIMORE, MARYLAND METRO CREMATORY 21. Signature WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** 48 HOURS /Medical Que to (or as a consequence of): Examiner 48 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 0.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 ☐ ER/Outpatient 3 ☐ DOA ate of Injury (Month, Day Year) 27. Manner of Ceath 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending efter death. investigation 1 ☐ Yes 2 ☐ No within 24 hours efter dea To the Funaral Director completely filled in by th 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Nam and address of person who complete

FEB 0 9 2005

31. Date filed (Month, Day, Year)

HAVRE dE GRACE.

eath (Item 23a) (Type, Print)

Registrar's Signature

		1	For State Registrar	State of Maryland		rtment of H			ene g. No.)6	03666
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	hysicia /Medic		Roxie Ann Johnsto	n			F	EBRUARY	4, 6	2006	11:10 A
	xamin		4a. Facility Name (If not institution, give st Saint Joseph M	reet and number) edical Cente	317	4b. City, Town, or	Location of Death	n	4c. County		imore
Fu	ıneral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreign ntry)
Dir	ector		215-22-8522	78	Yrs.			Mar 24,	1927	Flor	<u>ida</u>
and	* 1	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
Maryl	f eho	ō	MD Baltimore		Timon	Lum					1 ☐ Yes 2☐ No
the t	28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Cou	ntry?
death with the Maryland	38.0		12261 Round Wood R	oad #1414		210	93		USA	A	
deat	E E	Funeral Directo	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	ispanic Origin? (Sr In, Mexican, Puerto	pecify Yes or No-		ce - Ameri	can Indian, etc.
afte .	or its	Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X	1	☐Yes 2♥ No	Specify:		}	^b blac	
	ural,	d by	3 Widowed 4 Divorced	Year or Dates:	16a Deced	ent's Usual Occup	ation		6b. Kind of E		
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with iene.	the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	ps	ychothera	apist		health	care	
TG Z IZ I	othe ent,	a l	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	faiden Suma	me)	
yland outd be file Mental Hy	rked tic e	To B	Obdie Gilley					lia John			
ING, MATYIANG ZIZID-UUSO is 1 and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene.	# # # # # # # # # # # # # # # # # # #		19a. Informant's Name/Relationship (Typ	23-2			and Number or Ru				
and lealth	m 27 her ti	ļ	Daniel F. Johnston 20a. Method of Disposition			L Round W sition (Name of	lood Road		Lmoniui 20c. Location		
iges I	= : o : o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	con	netery, cren	natory or other place	(8)			,	•
altimore, mit. Pages 1 ar	ntant njury		4 ☑ Donation 5 ☐ Other (Specify)		22	. Name and Addre	ss of Facility				
Baltimore permit. Pages 1 Department of H	any ir		21. Signature of Figure License Ronald S. W	ade Vicetor	St		omy Board	1 655 W.	Baltin	ore S	Street
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused the death.				or respiratory arre	est,		Approximate Interval Between
Provs	sician		Immediate Cause (Final disease or condition	UPPER GASTE	ROINT	ESTINAL	BLEED				Onset and Death
/Me	edical		resulting in death)	Due to (or as a conseque	ince of):						
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fifficat	as the t	Medic									
Box	attending ph I for use as th	an/N	23b. was decedent pregnant	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal of	death 3□	Ectopic pregnancy	<i>,</i>			ate of deliver	very Dav Year
O. F.	the at	Physician/Me	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	4☐ Pregnant at time of dea 9☐ Unknown	ith 5□	Other (specify) _					,
Records, P.O.	signed by the a be detached f		Part II. Other significant conditions con-	tributing to death but not result	ting in the u	nderlying cause gry	ren in Part I.	23e. Did tob	acco use cor	ntribute to	the cause of death?
ds,	signe d be	d by	SEPSIS					1 □ Ye	s 2 No	3 ☐ Pro	obably 4 Unknown
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He is	e has age 2	Completed						autops perforr	ned?	death?	ompletion of cause of 2 ⊠No
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ysici	direc	To B	examiner? 1 ☐ Yes 2 🕱 No	ospital: 1 Malnpatient 2 □ E	R/Outpatier	nt 3□ DOA Ott	ner: 4 ☐ Nursing H	fome 5 ☐ Reside	nce 6 🗆 O	ther (Spec	ufy)
VISION Of VITAL Attending Physician: or death.	tor: After this certificate has the funeral director, page 2		27. Manner of Death 1. Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe ho	w injury occu	rred	
ISIO Nttendi death.	tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	and the section of the	20 form at		Yes 2 □No	28f Location /SI	reet and Nun	ther or Ru	ral Route Number,
or At	Director: in by the	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, rarm, sti	eet, factory, office		City or Town	n, State)	iber or riu	ar noolo number.
Hospita 4 hours	Funeral ely fille	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my know her: On the basis of examination	rledge, deat on and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and r ate and place	nanner as o, and due	stated. to the cause(s)
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			30. Name and address of person who co	mpleted cause of death (Item:	23а) (Туре,	Print)				1	
		242	TIMOTHY LOW, M. D. 31. Date filed (Month, Day, Year)	7601 DSLE 32. Registrar's Signatu	R DR	IVE TOW	SON MAR	YLAND 2	1286		
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	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year F 72 - 4 M									
	/Medic Examin	al	1) R, AN LeRoy Re, An Aspectation of Death Accounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	Examin	ei	BALTIMORE VAMEDICAL CENTER BALTIMORE N/A									
	Funeral Director		5. Social Security Number 220-64-8378 6. Sex 120 M 2 F 7. Age (In yrs. last birthday) 49 Yrs. 140 Months Days Hours Min. 02/09/1956 9. Birthplace (State or Foreign Country) MARYLAND									
	yland IOW		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
	Sa-fah	Director	MD N/A BALTIMORE CITY ¹XI Yes 2 □ No									
	23a or 24	ral Dire	10e. Street and Number 1102 DRUID HILL AVENUE 10f. Zip Code 21201 10g. Citizen of What Country? USA									
920	be filed within 72 hours after deeth with the Maryland stal Hygiene. ad other than "natural", or itama 23a or 28a-f ahow avent, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Warried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? US IN Yes, 2 No US IN Yes, 2 No Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? US IN Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes X No Specify: Specify: BLACK									
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	of Health of Health other tre		GABRIELE G. KEITH/WIFE 846 N. EUTAW ST., BALTIMORE, MD 21201 20a. Method of Disposition (Name of Disposition (Nam									
altimore,	Page nent o ant: If ary or		1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State Catonsville, MD									
Bal	permit. Departri Importe eny Inju		21. Signature of Pineral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD									
	Physician /Medical		23a. Plate En r the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Fig. 1. Luck C Due to (or as a consequence of):									
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·	be executed icien and burial-transit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cirrhosis C. Due to (or as a consequence of):									
8760	cate be ex physicien the buria	dlcal	d									
P.O. Box 6	the attending the attending hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth \ 2 \] Fetal death 3 \[Ectopic pregnancy \ 5 \] Other (specify) \[Solution = 1 \] 23d. Date of delivery 23d. Date of delivery 4 \[Pregnant at time of death 9 \] Unknown									
	uires that the signed by Id be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown									
of Vital Records,	The law requir ate has been si page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No									
Vita	Physician: this certificant	Be	25. Was case referred to medical examiner? Hospital: Open to the control of the									
of	Phys or this oral dia	To	21 Hoursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
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Division	after de Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To th withir To th comp	Me	29b. Signature and the of certifies. 29c. License number 29d. Date signed (Month, Day, Year) 16767 FeBRUARY 3 206									
	(2)		30. Name and address of person who comes ed cause of death (Item 23a) (Type, Print) BREENESTREET BALTIMORE MD 21201									
ile T	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 9 2006									

DHMH 17 Rev 1/2001

		1	For S	tate of Maryland		ent of Healt ate of Dea			ene . 10 0 6	03668
1,3	Physicia /Medic	an	Decedent's Name (First, Middle, Last)	Archie	Lev	vis	2	Date of Death Month	Day 7, Yeary 7, Zo	3. Time of Death
) 	Examin Funeral	er	4a. Facility Name (If not institution, give stre Striction (1'2 Ab - 4'h) 5. Social Security Number 6. Sex 218-05-0407	of and number) VM V SIMB 7. Age (In yrs. la 20 F	enter		more	Date of Birth (Month, Day, 1)	Ac. County of D N (ear) 1917 M R 1917	
* *-4	Director		Usual Residence of Decedent 10a. State 10b. County		Town or Location			AR 10,	1)11	10d. Inside City Limits 1 XYes 2 No
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f show mportant: If item 27 ie marked other than "natural", or items 23a or 28a-f show propriating of injury or other traumatic event, the Modical Examinar mantice notified at angle.	by Funeral Director	3503 Copley Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in U.S Armed Forces? 1 ₫\Pes 2 □ No If Yes, Give Year or Dates: WWII		21215 ecodent of Hispanic specify Cuban, Mex		fy Yes or No- can, etc.)		mencan Indian, Ihite, etc. African American
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Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Albert E. Lewis			18. M	· ·	First, Middle, M e Brown	aiden Sumame)	
	1 and 2 should Health and Men tem 27 ie marke		19a. Informant's Name/Relationship (Type, Linda L. Ross/Daugh			ress (Street and Nu			City or Town, Stat MD 21215	e, Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If ttem 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	ace of Disposition metery, crematory	(Name of or other place)	Dai		oc. Location - City Baltimore	
Balti	permit. Departm Importa eny inju		21. Signature Fu eral Service Licensee Edward A Grego	M cchik	22. Nam 299	e and Address of F Frederic	^{acility} Cre k Road	mation Baltim	Society ore, MD	ot MD, Inc.
0.00	Physician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ions that caused the death cause on each line. Metastat	Do not enter the	L. I	Canc		st,	Approximate Interval Between Onset and Death MIN HIS
V	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t	ence of): v	llitus				y-ears y-ears
8760,	cate be executed oblysicien and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequence of the control of the c	ence of):	al fai	lure			years
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ector	r (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributed by perting of the	outing to death but not resu	Iting in the underly	ing cause given in F	Part I.			e to the cause of death? Probably 4 Unknown
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Vita	0 9 6	Be	25. Was case referred to medical examiner?	pital:		1 - 1		Check only one		
of	Jing After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28		nce 6 Other (winjury occurred	Specity)
Division	5 # £ c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, street, fa	ctory, affice	28	Bf. Location (Str City or Town,		r Rural Route Number,
	To the Hospital of within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	ian: To the best of my known to the basis of examinat and manner stated.	wledge, death occu ion and/or investig	rred at the time, da ation, in my opinion	te and place, ar , death occurred	d at the time, da	te and place, and	due to the cause(s)
	Voithi Comp	Σ	29b. Signature and title of certifier	nyn	D	29c. License num	-391	4.1	ebruar	a de la companya de l
•	12		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, Print)	Balt	imore	Ma	ebruar vylamd	7,2006
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 9 2006	32. Registrar's Signa	ture				/	

			1 - For State Registrar	State o	f Marylan	-	artmen <i>tificat</i>			nd M	ental Hygie	ene 4.006)	03669	
	Physici		1. Decedent's Name (First, Middle, Last)	color							2. Date of Death Month		'ear	3. Time of Death 4:40A M	
	/Medic Examin		4a. Facility Name (If not institution, give s Riverview Nursing	treet and nur			4b. City,	Town, or Ess	Location of	f Death	62 6	4c. County of	Death	more Co.	
	Funeral Director		5. Social Security Number 6. Sex		7. Age (In yrs. 69	last birthday). Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Y	'ear)	Birthr	place (State or Foreign	
	show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Bal	timore		ty, Town or Lo	cation				Diii	ndalk		10d. Inside City Limits 1 ☐ Yes 2\(2\)XNo	
	with the Manuel Sa or 28a-f	I Director	10e. Street and Number 7223 Martell Ave				10f. Zip	Code	21:	222		. Citizen of Wh	/hat Country?		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner rust be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 ∏Yes If Yes, Giv Year or D	2 [₹No ⁄e	l	Was Deced Yes, spec	ofy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	within 72 ho ene. than "natur he Modical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8 Years		-4or 5+)	16a. Deced (Give life. L		rk done d se retired)	uring most	ol workii	working 16b. Kind of Business/Industry Child Care Provider				
yland	m == 0 %	To Be C	17. Father's Name (First, Middle, Last) James E. Jones								(First, Middle, Ma Chastair				
e, Mar	1 and 2 sho Health and Sm 27 is m ther traum		19a. Informant's Name/Relationship (Ty Ms. Bonnie G. Fra 20a. Method of Disposition			1213	Nar	cissu	nd Numbe 1S AV	e. :	Rosedale,		and	21237	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es once.		·	1X Burial 2 Cremation 3 Removal from State 4 Domation 6 Other (Specify) Christ Lutheran Church									inda Ind	alk, MD	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Hypu	aused the deat ach line.	th. Do not ent	er the mod	e of dying	g, such as	cardiac o		t,		Approximate Interval Between Onset and Death	
8760,		dical Examiner	Sequentially list conditions, than, ladding to furn ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		or as a conseq										
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α.	quires that in signed b uld be deta		Part II. Other significant conditions con Clame Kidney	tributing to d		sulting in the u	nderlying o	ause give	in in Part I.					he cause of death?	
Records,	The law requir ate has been si page 2 should l	Completed	Doestes Melleto	\$							24a. Was an autopsy performe	d? pri	or to co	opsy findings available impletion of cause of	
of Vital	Physician: The this certificate had director, page	To Be	examiner? 1 Yes 2 No								n (Check only one) me 5 ☐ Residen	ce 6 □Other	(Specii	-	
Division of	Attending Ir death. ector: After by the funer	ertification:	27. Manner of Death 1								28c. Injury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred				
_	To the Hospital or within 24 hours affer To the Funeral Dircompletely filled in I	edical Ce	29a. Certifier 1.☐ Certifying Physical (Check only one) 2 ☐ Medical Exami	ner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the cau ed at the time, date	se(s) and manr and place, an	er as s	tated. o the cause(s)	
)	To the within To the comp	M	29b. Signature and title of certifier	and)			License	number			I. Date signed (
1	3		30. Name and address of p n who co Michael Schwartz	M.D.	1 Easte	rn Ave		sex,	Mary	land					
:	Sta	ite	31. Date filed (Month, Day, Year)	006 32.	egistrar's Signa	atupa	1846								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2, perf/kr, C852, 2/10/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 3. Time of Death Dav **Physician** Month JOSEPH GEORGE MASTOWSKI el mecon 1420M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3009 old Stage Kand aure 6 coles 5 6 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, March 9, 1 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1. M 2 □ F 174-44-2461 54 Yrs Director 1951 Michigan Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince George's Laurel Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 13009 Old Stage Coach Road Apt 1718 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Wever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Comp Elementary/Secondary (0-12) College (1-4or 5+) 2 years Electrical Engineer **PEPCO** other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be nent of Health and Mental Clarence M. Mastowski Evelyn E. Mandziara 2 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn E. Mastowski / mother 520 White Road f Health Normalville, PA 15469 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Importent: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Raymond Cemetery | 2/11/2006 Saltlick TWP, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 45 313 Talbott Avenue Laurel, Maryland M00770 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CATOLOUAS CULON Physician Atherosel enotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a contactianna di death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2: autopsy performed? certificate 2 No 2 No 1 🗌 Yes 1 Yes Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannes of Death 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1-Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No death 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ō Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year) 11005 2006

State

Registrar

10000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

FEB 0

3001

32. Pagistrar's Signature

February 4, 2006 5:20PM

MISAK, ANTONIA Division of Vital Records, P.O. Box 68760, +

		For State Registrar	Please	State of Ma		Depart		lealth and	Mental Hy	Reg. No.	03671
ALCOHOL:	ician		ame <i>(rirst, Middle, L</i> as On i na	В	Mis	ak			2. Date of De Month Februa:		3. Time of Death 5:20 PMM
	dical niner		e (If not institution, give	street and number)			o. City, Town, o	r Location of Deat		4c. County of D	
7:8 	. ₍₅) 4	5. Social Securit	lla Maris	7 Δα	e (In yrs. last b		Timoniu Under 1 Year	m If Under 24 Hrs	8. Date of Bir	Baltimo	
Funer Directo		102-36- Usual Residence	-1889	7 0 -	80		onths Days	Hours Min.		y, Year) 1925 Po	Birthplace (State or Foreign Country) Land
ryland		10a. State	10b. County		10c. City, Tox	wn or Locati	on				10d. Inside City Limits
he Ma 28a-1	ecto	MD 10e, Street and	Baltimor	e	Caton	svill					1 ☐ Yes 2 ☐ No
3a or 3	10		veland Road				10f. Zip Code 212	28		10g. Citizen of What USA	Country?
ire, Marry latin Z 1 Z 13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. The Arrive of the William of the Maryland is a constituted other than "natural; or items 23a or 28s-f show other traumatic event, the Macdical Examiner and the mattles at	by Funeral Director	11. Marital Statu		12. Was Decedent Amed Forces? 1 Yes 2 N Yes, Give X Year or Dates:				ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		merican Indian, Thite, etc. White
72 hou	ted	(6)	15. Decedent's Ed	ucation	168	a. Decedent	's Usual Occup	ation	411-	16b. Kind of Busine	
within in the wed	Completed	Elementary/Se	econdary (0-12)	College (1-4or 5	+ ⁾ J	life. DO	NOT use retired	during most of wo	rking	Maintenan	ce
Mary land 2 12 13-0030 d 2 should be filed within 72 hours af th and Maral Hygiens 77 is marked other then "natural", or traumatic event, the Magical Exami	To Be C	17. Father's Nan	ne (First, Middle, Last) Buranicz						me (First, Middle, Unknown)	Maiden Sumame)	
Ce, Maryla 1 and 2 should Health and Men lam 27 is marke		19a. Informant's Maria M	Name/Relationship (T Iisak (D	урө, Print) aughter)				and Number or Au Rd. Cat		er, City or Town, State	
Daltimore, M permit. Pages 1 and 3 Department of Health importent; if itam 27 eny injury or other tre			Disposition 2			ery, cremato	on (Name of ory or other place & Paul	2-9-	Date -06	20c.Location · City Waterford	
Departiment import	OUCE.	21. Signatur	Funeral Service Licens	200	O QL) 滑机	tzgeral	d Funera Blvd.	1 Home Cohoes,	NY 12047	
Physicia /Medic: Examine pue and purial-transit price purial-transit pri	al	23a. Part I Ent Shock or I Immediate Caudisease or condresulting in deat Sequentially list if any, leading to cause. Enter Ur Cause (Disease that initiated everesulting in deat	conditions, o immediate identifying or injury ints	a	a consequence	om of):		g, such as cardia	c or respiratory a	rest,	Approximate Interval Between Onset and Death
the death certificate the attending physiched for use as the	by Physician/Medical	IF FEMALE: 23b. Was deced in the past 1 □ Yes 9 □ Unkno	12 months? 2 No	d23c. If yes, outcome 1 \(\subseteq \text{Live birth} \) 4 \(\subseteq \text{Pregnant at} \) 9 \(\subseteq \text{Unknown} \)	2 Fetal deat		opic pregnancy her (specify)			23d. Date of Month	delivery Day Year
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vical necolus, icien: The law requires t certificate has been signe rector, paga 2 should be c	e Completed	25. Was case re	ferred to medical	A2 - V(1) A2				OC Place of De	24a. Was autor period 1 Yes	prior in the prior	autopsy findings available to completion of cause of ? es 2 \sum No
	ToB	examiner?	_	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient :	DOA Oth	0.00	tome 5 Resid		pecify) HOSPICE
ng fter		27. Manner of Do 1 Natural 2 Acciden	5 Pending	28a. Date of Injur (Month, Da)		Time of Injury	28c. Injun Work M 1	yat k? Yes 2 □ No	28d. Describe	now injury occurred	
그 등 등 등	Certification:	3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could not be determined	28e. Place of Inju- building, etc	iry - At home, f c. (Specify)	arm, street,	factory, office		281. Location (: City or Tox	Street and Number or vn, State)	Rural Route Number,
To the Hospitel within 24 hours a To the Funerei I completaly filled	edical (29a. Certifier (Check only one)	1 X Certifying Phy 2 Medical Exam	sician: To the best iner: On the basis of and manner sta	examination a	e deam un nd/or invest	curned at the tin igation, in my o	ne date and place pinion, death occu	and due to the irred at the time,	Dauce(s) and mainer date and place, and c	us state 1. due to the cause(s)
To th withir To th	Ž	29b. Signature a	nd title of certifier				29c. License			29d. Date signed (Mc	onth, Day, Year)
		•	0/11.				リカム	3725		2/6/0	06
)		TARIG	ddress of person who d	nood. A	1.D	(Type, Prin	23	00 Du	lane	2/6/0 Valley D 216	RD.
Regi	State strar	31. Date filed	EB 0 9 2006	82. Registra	r's Signature	back	p	TONTU	vri, Pi	D die	

			Please T	ype or Print in Black Inde	elible lnk. Ensure A	II Copies Are	Legible.
			1 - For State Registrar	State of Maryland / Depart	tment of Health and I ficate of Death	- (UU0 UJ014
	Physici /Medio		1 Decedent's Name (First, Middle/Dist)	mish Massoud		2. Date of Death Month	3. Time of Death
	Examin		4a Facility Name (If not institution, give s 5. Social Security Number 6. Sex	,	b. City, Town, or Location of Death	8. Date of Birth	Bathmore 9. Firthplace (State or Foreign
	Funeral Director		313-28-5898 1 Usual Residence of Decedent		Months Days Hours Min.	1-15-19a	25 Philippines
	hours after death with the Maryland turel', or Items 23s or 28s-f show at Examinational tempolitied at	ector		nure Baltin	nore		10d. Inside City Limits 1 ☐ Yes 2
	s 23s or 2	Funeral Director	600 Light Street	t, Apt. 830 2. Was Decedent Ever in U.S. 13. Wa	10f. Zip Code 21230		Citizen of What Country?
9036	ours after d ral', or Item Evander	by	11. Marital State 1 Never Married 2 Married 3 Vividowed 4 Divorced	Armed Forces? If Y	s Decedent of Hispanic Origin? (S) es, specify Cuban, Mexican, Puerto	o Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	d within 72 jiene. rr then "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give kin	it's Usual Occupation Id of work done during prest of won NOT use retired) Hered Nurse	king 16b.	Thimore City Jail
Maryland	a la b	To Be	17. Father's Name (First Middle, Last) Nation Suva 19a. Informant's Name/Relationship (Type)	ad Print) 19h Mailing	18. Mother's Nam	ne (First, Middle, Maide	unk
-	s 1 and 2 s if Health ar ftem 27 is other trau		Herman Canish 20a. Method of Disposition	Son 3865	Twin lakes Ct	Windson	1/11/ 00 000/11/
Baltimore	permit. Page Depertment of Important: If any injury or once.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Sigt vure of runeral Service License	Arbutus 1	hemorial 2-1	0-06 Ar	butus, MD
	20.200		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final	eations that caused the death. Do not enter to e cause on each line.	28 Ki berty Kd. he mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)		АТНҮ		
,09	be executed sicien and burial-transit	ai Examiner	Sequentially list conditions, a y leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of):			
P.O. Box 6876	res thet the death certificate be igned by the attending physicie be detached for use as the bur	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown		itopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
rds, P.	The law requires thet the sie hes been signed by the bage 2 should be detache		Part II. Other significant conditions con	ributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Σ ξ	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	04	th Check only one	OF CONTRACT HOCDION
Division of	To the Hospitel or Attending Phy within 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral or	ation: To	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	6 X Other (Specify) HOSPICE ury occurred
Dİ	tel or Att rs efter de al Direct ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ne Hospitei or n 24 hours effe ne Funerai Dir bletely filled in	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	cian: To the best of my knowledge, death or er: On the basis of examination and/or inves and manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the cause(rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the To the complet	×	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year) 2/8/06
	H		DR. TARIQ MAHMOOD	npleted cause of death (Item 23a) (Type, Pringleted Cause of DULANEY VALLE)	nt)	MD 21093	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 9 20	32. Registrar's Signature			

DHMH 17 Rev 1/2001

_			1 - State Registrar Amend Item 20	State of Maryla 1b Per PH G8				-	20006	03673
	Physici /Medio		Decedent's Name (First, Middle, Last) SIDNEY			ONEN		2. Date of Death Month Februa	Day Year	3. Time of Death 6 1950 p M
) 	Examir	ier	4a. Facility Name (If not institution, give str UNION MEMORIAL HO	SPITAL		4b. City, Town, o	BALTI	MORE	4c. County of Dea	N/A
	Funeral Director		5. Social Security Number 6. Sex 18-09-5501		s. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		920 9. Bir	thplace (State or Foreign ountry) MD
	Maryland	tor	10a. State 10b. County N/A	10c. C	City, Town or Lo	IMORE				10d. Inside City Limits
	h with the 23a or 28s	al Director	10e. Street and Number 2211 W. ROGERS AVE	NUE		10f. Zip Code	21209		. Citizen of What Co	ountry? USA
920	within 72 hours after death with the Maryland ene. then *neturef; or fteme 23e or 28e-f ahow ta Mudical Exerci or trival by rivilling at	by Funeral	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Was Decedent Ever in Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	permif. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ftema 23a or 28a-f ahow any injury or other traumatic event, Ita Mudical Exant art must be multied at once.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of w	vorking	REAL ES	
yland ;	should be filed ind Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) SOLOMON		MONE	N	18. Mother's N	ame (First, Middle, Ma	iden Sumame)	NELSON
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type PATRICK D. DONLY /	STEPSON	21 C	LARENDON	AVENUE	- BALTIMOR	E, MD 212	08
timore	. Pages 1 tmenf of H tant: If iter jury or oth		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	soval from State	Cemetery, crer VETER	esition (Name of matory or other place ANS CEMET	ERY 02/	07/2006		MILLS, MD
Bai	permif. Departimporti		21. Signature of Funeral Service Licensee	ettle		900 REIST	ERSTOWN	OL LEVINSO ROAD - PI	KESVILLE,	MD 21208
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	cause on each line.	-05e	ps i s	g, such as caro	ac or respiratory arrest	,	Approximate Interval Between Onset and Death
8760, <	sate be execufed physician and the burial-fransit	dical Examiner	cause. Enter Underlying Cause, Issease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 6	The law requires that the death certifica lie has been signed by the attending ph aga 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregi 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	quires that in signed k uld be deti	by	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause give	en in Part I.		2 No 3 Pr	o the cause of death?
Il Records,		Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1 Inpatient 2[] ER/Outpatien	t 30 DOA Oth	35	eath (Check only one) Home 5 Residence	o 6 DOther (See	a.f.)
Division of Vital	ding After fune	F .		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how		ciry)
Divis	tal or Attendi s after death al Director: A ed in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my kr : On the basis of examinand manner stated.	nowledge, death nation and/or in	occurred at the time vestigation, in my of	ne, date and pla pinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the Mithin 24 To the Complete	Σ	29b. Signature and title of certifier	L PI	fan, M	D. AT			bruary	
No.	⊢ Sta	te	30. Name and address of person who com Tennifer 31. Date filed (Month, Day, Year)	Pleted cause of death (Ite	m.D.	Print)	n M	emorial p	Hospital,	-6,2006 Baltimore,MD.
	Registr	ar	FEB 0 9 2006	De Core	J. 1990	100				

			1 - For Amend Item	23a per Dr	aryland / •••G852	Depa ,02/	rtment of H	lealth a Death	ınd M	lental Hy	/giene Reg. No.	006	03674
. 5		4	1. Decedent's Name (First, Middle, La	st)						2. Date of De	eath		3. Time of Death
	Physic /Medi		Debra M	artin						Feb	Day	200 G	0 6444 AM
}	Exami		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	r Location of	f Death		4c.	County of Dea	ith
. 1	C 100 84 0 87		University of Mary				Sal	time		-		NIA	
模点	Funeral Director		212-98-9990	□M 2DNE	e (In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di 8-8-19	ay, Ye <i>ar</i>)	9. Bii C MD	thplace (State or Foreign ountry)
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits
	Marylan -f show	ţŏ	MD Anne Ar	undel	Pac	adena	2						1 ☐ Yes 2 No
	h the	Director	10e. Street and Number		145	aucin	10f. Zip Code				10g. Citiz	zen of What C	ountry?
	th wit	aD	8394 Armstrong Dr	ive			21122	2		Ì	U.:	S.A.	
	ter dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Orig	in? (Spe	ecity Yes or No	0-	14. Race - Am Black, Whi	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show deal Examiner must be putified at	by	1X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates:	No		☐ Yes 2000No	Specify:		r nouri, oto.;			hite
5-0	72 ho natur	Completed	15. Decedent's Ec (Specify only highest gra	ducation	16	Sa. Deced	ent's Usual Occupa	ation	of works	7.0	16b. Kir	nd of Business	/Industry
21	d within 72 ho piene. r than "natui ine Madical	nple	Elementary/Secondary (0-12)	College (1-4or 5		life. D	OO NOT use retired	1)	OF WORKI	ng			
2	il Hygiel other th		12 17. Father's Name (First, Middle, Last)			Cleri	ical Work						t Foundatio
Maryland	d la b	Be	Joseph Wayne Mar					Susa:		(First, Middle	, Maiden	Sumame)	
7	2 should and Men Is marke aumatic	ြ	19a. Informant's Name/Relationship		10	9h Mailine	g Address (Street a				or City or	Tour State	Zin Code)
	nd 2 state are are trans	Π.	Mr. Joseph Wayne 1	71							-		Zip Code)
ē,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		20a. Method of Disposition		20b, Place	of Dispos	Armstron			asaden		cation - City or	Town, State
Baltimore,	Pages nent of I ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				atory or other place. Mem Par		11	2006	Clar	. D.,	- MD
alti	글 본 분 출 .		21. Signature of Funeral Service Licen		oren i		Name and Addres				Fune	Burni	e, MD ma PA
m	Depa Impo eny i		Shannon W.	Berld Mi	10798	1	Second A	ve SW	; G1	en Bur	nie.	MD 210	61
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do	o not ente	r the mode of dying						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pan	Hype	erter	nsion	OAR					Onset and Death
100	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	7.0	7					JO 1100-3
Н	Lxummer	_	Sequentially list conditions,	b	Pont	tine	Hemorrha	ge					
	Pa isi	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):							
	and and II-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):							
8760,	cate be executed physicien and the burial-transit	dical											
687	ificate g phy as the	edic		d									
Вох	h cert endin use	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		a 🗆 r					2	3d. Date of de	ivery
<u>.</u>	that the death certified by the attending detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No	4 □ Pregnant at			Ectopic pregnancy Other (specify)					Month	Day Year
Р. О.	at the	Phy	9 □ Unknown										
Division of Vital Records,	sign sign d be	þ	Part II. Other significant conditions co	ontributing to death bu	ut not resulting	in the und	derlying cause give	n in Part I.		23e. Did to			othe cause of death? obably 4 Unknown
000	law requas been 2 should	Completed								24a. Was		24b. Were au	itopsy findings available
Ĕ	iician: The fav certificate has rector, pege 2	E								autor perfo	osy irmed? 200 No	prior to death?	completion of cause of
ta	ian: artifica ctor, I	Bec	25. Was case referred to medical examiner?					26. Place o	of Death	Check only o		1 163	44 110
<u>></u>	Physician: The this certificate har director, pege	2	1 ☐ Yes 2 No	Hospital: 1 X Inpatie	nt 2 ER/C	Outpatient	O# -					Other (Spe	cify)
בַ	ding P h. After t funera	e ::	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Oate of Injur (Month, Day	Year) 28b.	Time of Injury	28c, Injury Work	at ?	2	8d. Describe	now injury	occurred	
200	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be					′es 2∏No	0			-	
$\overline{\leq}$	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, f . (Specify)	arm, stree	et, factory, office		2	8f. Location (5 City or Tov		Number or Ru	iral Route Number,
_	spital ours neral filled		29a. Certifier 1X Certifying Phy	vsician: To the best of	if my knowledg	an death	occurred at the time	o deto end	-1		()		
	• Ho: 124 h • Fur letely	edical	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination a	nd/or inve	estigation, in my op	inion, death	occurre	d at the time,	date and p	olace, and due	to the cause(s)
	To the Hospital or Attending Physician: within 44 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director; g	Me	29b. Signature and title of certifier				29c. License	number	-		29d. Date	signed (Monti	h, Day, Year)
			Mittle Lel.	ul 1	MD		PIS	8345	_		Frh	07	7006
	n		30. Name and addre person who c	,	1	(Type, P					,00		
	9		Beth Jelinek MD	22 5. (preene	St	Baltir	nore	m	D 2	2120	51	
3 1	Sta		31. Date filed (Month, Day, Year) FEB 0 9 20	32 megistra	r's Signature	Lu	de			7.77		V -5 - 1 - 1 - 1	
-	Registr	ar	FEB 0 9 20	IUb Alle	10	1							

				For State Registrar	State of	Marylan		rtment of F tificate of	Health and M <i>Death</i>		giene Reg. No:	6 03675
		Physici /Medic		1. Decedent's Name (First, Middle, La		irran				2. Date of De Month	Day Y	3. Time of Death
		Examin		4a. Facility Name (If not institution, give BALTIMORE WASHIA		/ /	ENTER	4b. City, Town, of	BURNIE		4c. County of	
		Funeral Director		5. Social Security Number 6. S 012-26-4375		7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da 9-21-1	th ly, Year) .935	Birthplace (State or Foreign Country) MA
		ehow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Limits
		ith with the Maryla 23a or 28a-f ehor	Irecto	MD Anne Art	ınde1		Glen B	urnie 10f. Zip Code			10g. Citizen of Wh	1 ☐ Yes 2₹\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		23a c	rai D	206 Main Ave. SW	T			21061			U.S.A	
N	5-0036	72 hours after death with the Maryland naturel', or Iteme 23s or 28s-f ehow Jisal Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1 🛛 Yes If Yes, Give Year or Da	2 ∏ No e	If	Vas Decedent of F Yes, specify Cub ☐ Yes 2 ☑ No	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		American Indian, White, etc. White
귘	2	S 4	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ade <i>completed)</i> College (1-	-4or 5+)	(Give I	OO NOT use retire	during most of work	ing	16b. Kind of Busin	
4	land 21	lied Hygi her nt, 1	Be Co	17. Father's Name (First, Middle, Last)		LLTII	ter	18. Mother's Name	e (First, Middle,	Newspa	•
	ylar	should be fand Mental Bernarked of	To	Michael J.		1,21	T 481 14 11			M. More		
ORTON	Σ	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Mrs. Mabel J. Not		ife			and Number or Rura 2. SW; Gle			
108	altimore,	ages 1 a nt of Heam : If Item		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐	Removal from S	20b. P	lace of Disposemetery, crem	sition (Name of natory or other pla	(ce)	Date	20c. Location - Ci	ity or Town, State
2	altin	permit. Pages Depertment of I Important: If Ite eny injury or of		4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lices		Mar	22.		ass of Facility Si			Home, PA
	8	80 = 9 9	0))	23a. Part 1. Enter the disease, or com	plications that ca	Mo/			Ave SW; G			Approximate
4	,	Physician		shock, I heart failure. List only tmmediate Cause (Final disease or condition resutting in death)	one cause on ea	ach line.	Sea	tie	efort			Interval Between Onset and Death
		/Medical Examiner			Due to (d	or as a consequ	ience of.	te u	and de	lun	•	
	10	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dualto (c	or as a consequ	ranca of):		- 12	ol .		
	,09289	icate be executed physiclen and s the burial-transit	dical Exa	resulting in death) Last	C. Due to (d	or as a consequ	uence of):	,,,,,,,,				
	x 68	U 14 (A		IF FEMALE:	20. 1							
	P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the ettending fr tal director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnance Other (specify)	у		23d. Date of Month	
	rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	ontributing to de	ath but not resu	ulting in the un	derlying cause giv	ven in Part I.			ute to the cause of death?
	of Vital Records,	The law recate has be page 2 sho	Completed							24a. Was autor perfo 1 Yes	rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
	Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital: 1 Cur	patient 2	ER/Outpatient	3□ DOA OU	26. Place of Death			(Space)
	n of	ing Phy After this uneral c		27. Manner of Death 1 Natural 5 Pending		of tnjury h, Day Year)	28b. Time of Injury	28c. Injui	ry at		how injury occurred	
	Division	To the Hospital or Attending Physical Burners of Lours atter death. To the Funeral Director: After this completely filled in by the tuneral directors.	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of Injury - At ho	me, farm, stre	M 1 (Yes 2 No	28f. Location (S City or Tox		or Rural Route Number,
	_	e Hospita 124 hours Funeral letely filled	dicai	one) 2 Medical Exam	miner: On the ba and mann	isis of examinat ier stated.	ion and/or inv	estigation, in my o		red at the time,	date and place, and	d due to the cause(s)
		To th Within To th compl	Me	29b. Signature and title of certifier	-			29c. Licens	se number		29d. Date signed (Month, Day, Year)
		O,		30. Name and address of person who	completed cause	دــ e of death (Item	23a) (Type. I	DOC Print)	214147	> /	rebruay	12006
		,		305 Hospital	Dr S	u,te	305	6/m	Burnie	- ML	2101	
	1	Sta Registr	ite rar	30. Name and address of person who 3.5 H-Sulfal (Month, ay, Year) FEB 0 9	2006	Bees .	N. A	mede				

Amend item#5, per 13, 852,22,966 First in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** y 2,2006 4c. County of Defath oms ebruary /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 7. Age (In y/s. last birthday) Timore HO 6. Sex 8. Date of Birth (Month, Day, 9. (Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Yrs. (acolina Director North Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23s or 28s-f show the Medical Exempler must be notified at Maryland 1 Yes 2 □ No Director timore 10e. Street, and Number 10f. Zip Code 10g. Citizen of What Country? dd 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Blac 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired), 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other then eny injury or other traumatic avant. Elementary/Secondary (0-12) College (1-4or 5+) hanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be xander er See aom 19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smallwood dom 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2h to Rus Aue Approximate Interval Between Onset and Death Months Part V. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) metastatic **Physician** lung cancel /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and dbe deteched for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Inter (Specify) HOSPICE Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A after 4 Homicide To the Hospital of within 24 hours aft To the Funerel Di 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier D24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Entaw St Richey Hospice E. TSOMD 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 9 2006 Registrar

	1 - For State Ragistrar	State	of Marylan	-	artment <i>tificate</i>				1ental Hy	giene Reg. No.	006	5 (0367	7
an	1. Decedent's Name (First, Middle To Sephi)	_	reasy	P	orter				2. Date of Do Month Februa	Day	, 20	Year 06	3. Time of De 12:45	
al ier	4a. Facility Name (If not institution Laruel Regional				4b. City, 1	Town, or	Location	of Death	<u> </u>	4c.	County o	f Death	orge's	
	5. Social Security Number 228-07-8264	6. Sex 1 □ M 2 → F	7. Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth		9. Birthp	lace (State or F	oreig
	Usual Residence of Decedent 10a. State 10b. Count	y	10c. Cit	y, Town or Lo	cation	1		1				1	0d. Inside City	Limit
Director	MD Princ	e George	s Lau	ırel	10f. Zip	Code				1 → No 10g. Citizen of What Country?				
	7326 Summerwind	Circle			207					-	.A.			
d by Funeral	11. Marital Status 1 □ Never Married 2점 Ma 3 □ Widowed 4 □ Divorce	rried 1 Tyes	cedent Ever in U. Forces? s 2 2 No Give Dates:	1	Was Decede f Yes, spec l ☐ Yes 2	ify Cubar	spanic Or n, Mexical Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-		- Americ White, Whi		
ompleted		nt's Education est grade complete College	d) (1-4or 5+)	(Give lite. l	dent's Usua kind of wor DO NOT us eticia	k done di e retired)	tion uring mos	st of work	ing		nd of Bus)rug			
To Be C	17. Father's Name (First, Middle Otis William Ro						18. Mother's Name (First, Middle, Maiden Surname) Gertrude Simmons							
	19a. Informant's Name/Relation James Porter	ship <i>(Type, Print)</i> / husbar	ıd		_				a/Route Numl Laure	-			Code) 20707	
	20a. Method of Disposition 1XX8urial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (m State C	lace of Dispo emetery, crer Vetera	natory or ot	her place	-		Date 2006				own, State	
	21. Signature of Funeral Service	e Licensee	M00770						Home, l		arvī	and	20707	
dical Examiner	23a. Part1. Ent-a the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Resp Due to b. Chro	t caused the death a each line. piratory o (or as a consequence onic Obst o (or as a consequence on o (or as a consequence o (or a (or a) (o	Failur uence of): cructiv	e fro	m CC	PD		or respiratory	arrest,			Approximate Interval Betwee Onset and Dea	en ath
ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	outcome of pregna birth 2 Feta gnant at time of d known	death 3	Ectopic pre Other (spe					1	23d. Date Mont		ery Day Yea	ar
d by Ph	Part II. Other significant condit		death but not res	ulting in the u	nderlying ca	use give	n in Part I	l.	1	tobacco u			ne cause of dea abiy XXUni	
Complete	DM type II Coronary Ar	tery Dise	ase						24a. Wa: auto peri 1 Yes	s an opsy formed? 2 XXo	pr de	ere auto ior to cor ath? Yes	psy findings ava mpletion of caus 2 X Xo	ailab se of
atlon; To Be	25. Was case referred to medic examiner? 1 Yes 2 X Yo 27. Manner of Death 1 X Natural 5 Pend inves	Hospital: 15 28a. Dai (Mo		ER/Outpatier 28b. Time of Injury		Bc. Injury Work	^{IC} 4□Ni at	ursing Ho	h <i>(Check only</i> ome 5 ☐ Res 28d. Describe	idence (y)	
Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. Pla	ce of Injury - At he Iding, etc. (Specif	ome, farm, str	eet, factory,	office				(Street an own, State		r or Rura	l Route Numbe	Γ,
ledical	(Check only 2 Medice		he best of my kno basis of examina anner stated.	wledge, deatl tion and/or in	vestigation.	in my op	inion, dea	nd place, ath occur	and due to the red at the time	, date and	place, ar	nd due to	the cause(s)	
Σ	29b. Signature and title of certif	alak i	Berzing	si, Me		DO 0	number	980	6		e signed / U 8/	1	Day, Year)	=
	30. Name and address of perso Chalak O. Be	erzingi, M	I.D. 75	00 Har	over		way	Suit	e 105	Gree	nbel	t, M	Maryland	i
ate rar	31. Date filed (Month, Day, Yea	9 2006	Pigistrar's Signa	iure	parke	,								

State of Maryland / Department of Health and Mental Hygien

PAUL	F.	PUFFENBARGER
		For State Registrar

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			1 - For State Registrar	otato or ma	. y (a. 1.a. / D	Certifi	icate of I		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	006	03678
			Decedent's Name (First, Middle, Las	ı)					2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Paul F Pufforbarger								2006	1329 P M
	Examir		4a. Facility Name (If not institution, give 205 BALTIMORE AV)		4b. City, Town, or Location of Death CUMBERLAND 4c. County of Death ALLEGANY							
	Funeral Director										place (State or Foreign intry) unk	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									10d. Inside City Limits
	Maryi -fehç	To Be Completed by Funeral Director	MD Allegany	7	Cur	ber1	and					1 ☐ Yes 2√∑ No
Maryland 21215-0036	r 28a		10e. Street and Number	,	Cuii		Of. Zip Code			10g. Citize	en of What Cou	intry?
	th with		205 Baltimore Ave	enue #313			215	02			USA	
	r dea		11. Marital Status unk	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of H	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No-	. 14	I. Race - Ameri Black, White,	
	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be inclified at		1 Never Married 2 Married 3 Widowed 4 Divorced	1 TYPes 2 □ No If Yes, Give Year or Dates:)		Yes 2∑No				Specify: wh:	
	netu		15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		Give kına	s Usual Occup of work done	during most of wor	_{king} unk	16b. Kind	d of Business/Ir	ndustry unk
12	withir ene. then		Elementary/Secondary (0-12) unk u	College (1-4or 5+	•)	ire. DO r	VOT use retired)				
d 2	filed Hygir other		17. Father's Name (First, Middle, Last)	IIK			unk	18. Mother's Nan	ne (First, Middle,	Maiden S	umame)	unk
a	should be ind Mental s marked o umatic eve											G.I.I.
Mary	47 tr		19a. Informant's Name/Relationship (7)	ype, Print)				and Number or Ru eet Balt			Town, State, Zij 1201	o Code)
ē,	s 1 and 2 of Heelth Item 27 other tr		20a. Method of Disposition		20b. Place of I	Dispositio	n (Name of ry or other plac	a)	Date	20c. Loca	ation - City or T	own, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify,				., ., ., ., ., ., ., ., ., ., ., ., ., .					
Baltimore,	permit. Pages 1 and Department of Heell Important: If Item 2 any Injury or other 2008.		21. Signifure of Funeral Service Licensee Street or State Anatomy Board 655 W. Baltimore Street									Street
			23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition Approximate interval Between Onset and Death of the condition									
	Physician											
	/Medical		resulting in death)		consequence of		7(11)			. ,		
	Examiner		Sequentially list conditions.	b								
	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
_	certificate be executed ding physicien and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
9	sicien buria			_		,						
68760,	ertificate ing phys e as the	Medical	d									
Вох	death e etter d for u	Physician/I	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow						23	23d. Date of delivery Month Day Year		
P.O.	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									he cause of death?
Sp	w requires that s been signed t s should be det	q p	Chronic obstructive palmonary disasse 10 Yes							′es 2□	2 No 3 Probably 4 Unknown	
င္ပ	w red	Medical Certification; To Be Completed by		, , , , , , , , , , , , , , , , , , , ,					24a. Was	an	24b. Were auto	opsy findings available
æ	Physician: The law r this certificete has t ral director, page 2 s							·	autop perfor	med?	prior to co	empletion of cause of
ta	lan: rtifice stor, p		25. Was case referred to medical					26. Place of Dea	The state of the s	2 □ No □	1X Yes	2 □ No
<u></u>	Physician: rthis certific ral director,		examiner?	fospital: Other							M AT SCENE	
=	Attending Pt r deeth. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury						cribe how injury occurred		
	2 # 5 C		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farn (Specify)	At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					al Route Number,	
	To the Hospital within 24 hours e Youth 24 hours To the Funeral Completely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier									
	To th withir To th compl		29b. Signature and title of certifier	4			29c. License				signed (Month,	
			· Caballa	as Ar-	-		0.	C.M.E		JAN.	31, 20	06
			30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (T	Nº ST	REET, B	ALTIMORE	, MARYLAN	D 212	201	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	9	18 0					
	Registr	ar	EFRA 9 78	06 6	A L		To the state of th					

			For State	State of Maryland	d / Department o Certificate		Em	006	03679
			Registrer 1. Decedent's Name (First, Middle, Last)		Centificate	or Death	Reg. No. 2. Date of Death		3. Time of Death
	Physicia /Medic	al	MARJORIE G	WEN R	DGERS 46. City. Toy	wn. or Location of Death	Month Day 4 4c.	County of Death	0 10:42 AM
	Examin	HOPICE OF THE CHESAPEAKE LINTHICUM ANNE ARUNDE							
es fir	Funeral Director		5. Social Security Number 6. Sex 10 h	7. Age (In yrs. Ia	3 Yrs. If Under 1 Y Months D	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birth Con	nplace (State or Foreign untry)
- E.	U	-	Usual Residence of Decedent 10a. State 10b. County		, Town or Location				10d. Inside City Limits
	death with the Maryland me 23a or 28e-f ehow r must be rodified at	ţo	MD ANNE ARI	INDEL GI	LEN BU	RNIE			1 Yes 2 40
	or 28e	To Be Completed by Funeral Director	10e. Street and Number		10f. Zip Co	-	10g. Citi	izen of What Co	untry?
	leath w		1585 DULUNE	. Was Decedent Ever in U.S	S. 13. Was Deceden	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ocify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or items 23a or 28e-1 show air injury or other traumatic event, Ins Medical Examination must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates:	If Yes, specify 1 ☐ Yes 2 ☑		Hican, etc.)	Specify: 7).H177=
215-0036	within 72 hours after ene. then "natural", or ite re Musilia Exagina		15. Decedent's Educa (Specify only highest grade of	tion	16a. Decedent's Usual C	Occupation done during most of worki retired)	16b. Ki	ind of Business/	Industry
2121	within tene. then		Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM	AKER	DV	UN F	HOME.
	be filed tal Hygid d other event, II		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maiden	Sumame)	
, Maryland	2 should be and Mental le marked of aumatic eve		19a. Informant's Name/Relationship (Type	FELL DR	19b. Mailing Address (S	Street and Number or Run	I Route Number, City of	r Town, State, 2	Zip Code)
	1 and 2 thealth ar tom 27 le		ROBERT ROGERS	150N	815 CEDAR	BRANCH D	2. GLENBU	PNIE No ocation - City or	ID 21001
nore	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	1 00	ace of Disposition (Name emetery, crematory or othe		010 140	NOVE	P. MD
Baltimore,	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Licensee	FINE	22. Name and A	Address of Facility AN	470MY 61FTS 7532 CO-31356	RECUSTRA	E
m 	60 E 2 9		23a. Part1. Enter the disease, or complication	itions that caused the death	. Do not enter the mode of		HANCHER 1	1D 310	Approximate
	Physician	Medical Certification; To Be Completed by Physician/Medical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	1 1 .	Colon Can			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ					7
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):				
	cate be executed physicien and s the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
8760,	ate be e nysicien he buria		d.						
9	leath certifica attending ph afor use as t		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna				23d. Date of de	livery
.O. Box	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown				Month	Day Year
۵.	thet the		Part II. Other significant conditions cont	ibuting to death but not resu	ulting in the underlying cau	ise given in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
Division of Vital Records,	v requires t been signe should be						1 ☐ Yes 2	□No 3□P	robably 4 Dunknown
	The law retele has be page 2 sh						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	ding Physicien: h. After this certifice funeral director, p		25. Was case referred to medical examiner?				1 ☐ Yes 2 X No h (Check only one)		A district
			1 Yes 2 No		ER/Outpatient 3 DOA 28b. Time of 286	Other: 4 Nursing Ho b. Injury at Work?	ome 5 Residence 28d. Describe how inju	6 Other (Spe	scity souce
			1/ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
	i or Atte efter de Directo d in by ti		3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify					Street and Number or Rural Route Number, vn, State)
_	To the Hospitei or Attenswithin 24 hours effer deati To the Funerel Director: completely filled in by the		29a. Certifier / Certifying Physic (Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina	wiedge, death occurred at tion and/or investigation, in	the time, date and place, n my opinion, death occur	and due to the cause(s) and manner a d place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet		29b. Signature and title of certifier	and manner stated.	29c. I	License number	29d. Da	ate signed (Mon	th, Day, Year)
	2		The second	MH		1/5/551	Fe	6149	6,20%
			30 Name and address of person who cor	npleted cause of death (Item	1,234) (Type, Print)	19, 6 KLBU	in, M	1.210	61
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature South	,			

		For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of H		ental Hygiene	(UU)	03680		
Phys		Decedent's Name (First, Middle Louise Rina	•		2. Date of Death Month Pay February 8, 2006 3. Time of Death 10:00a M						
/Me Exan	dical niner		4a. Facility Name (If not institution, give street and number) 4b. City,				4c.	4c. County of Deeth Howard			
Funer				Age (In yrs. last birthday, 98 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthp Coun	lace (State or Foreign stry)		
Pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				0d. Inside City Limits		
the Man 28a-f eh	Director	Md. How	ard	Ellico	ott City		10g, Cit	tizen of What Coun	1 ☐ Yes 2 🛣 No		
23a or	al Dir	9950 Oakle	a Ct.		210			USA			
irs after dea	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3X Widowed 4 Divorced	12. Was Decede Armed Force ad 1 Yes 2 If Yes, Give Year or Date	Š No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√2 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.		
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "natural", or items 23s or 28s-f show event, its Medical Exams are must be notified at	Completed		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry		
a filed w Il Hygier other ti	e Co	17. Father's Name (First, Middle, I	ast)		Homemak		(First, Middle, Maiden	Home Surname)			
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental Hygiene.	ToB	John Farrne		19b. Mail	ing Address (Street a		ualina Todesco Bural Route Number, City or Town, State, Zip Code)				
ges 1 and 2 should to f Health and Mer if Item 27 is marks or other treumatic		Charles Rinau		9910	Postwick	Rd.Ellico	ott City,Mc	1. 21042			
permit. Pages 1 and 2 Department of Health a Important: if item 27 is		20a. Method of Disposition 1 2 Burial 2 Cremation 4 Donation 5 Other (Sp.		Crest La	ematory or other place ewn Memori	al 2/13	3/2006 Marr		le,Md.		
permit. Departinimports	SUC.	21. Signature of Funeral Service 1	icense de la company				ry H.Witzk Pike Ellico		ly F.H.Inc. Md. 21043		
Physicia		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause only one cause on each	sed the deeth. Do not en line.	Λ	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death		
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pe pist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	ав а полвеционов of):							
or ou, sate be executed shysician and the burial-transit	dical Exar	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):							
The Could by F.C. box on the low requires that the death certificate be executed at has been signed by the attending physician and asge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 ☐ Fetal deeth 3 t at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year		
w requires that it been signed by should be detailed.	ed by Ph	Part II. Other significant condition	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Death in the underlying cause given in Part 1.					co use contribute to the cause of death?			
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To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours attendeath. To the Funeral Director: After this certificate has been signed by the attending procom, letely filed in by the funeral director, page 2 should be detached for use as a	Certification: To Be	25. Was case referred to medical examiner?	ation		of 28c. Injun Worl	en: 4 □ Nursing Ho y at k? Yes 2 □ No	ath (Check only one) come 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
JONES after de Directe	ertifle	3 Suicide 6 Could r 4 Homicide determ	200. Place 01	Injury - At home, farm, s , etc. (Specify)	treet, factory, office		28f. Location (Street as City or Town, State		l Route Number,		
the Hospitel or hin 24 hours after the Funeral Dir	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Check only one) Check only one)									
To the To the Company	×		210		29c. Licens	e number 263681	29d. Da	ate signed (Month, $2/8/6$	Day, Year)		
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	State istrar		9 2008 2	estrar's Signature	fore			yg. 1. 19. 1. 19. 1. 19. 19. 19. 19. 19. 1			

DHMH 17 Rev 1/2001

			For State Registrar	State of Mar	ryland /		tment					giene	000	03681	
	Physici	20	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Da	y Year	3. Time of Death	
	Physici /Medic			Robinson	n						1/	2	6/06	1:45 A	1
}	Examin	er	4a. Facility Name (If not institution, giv				4b. City, T	fown, or	Location	of Death		40	County of Dea	th	
	Funeral	90° ;	Coastal Hospice 5. Social Security Number 6.5		(In yrs. last I	birthday)	If Under	Year		24 Hrs.	8. Date of Birti (Month, Day	h .	VICO N 9. Bir	thplace (State or Foreig buntry)	ın
	Funeral Director			1 ₹M 2□F	76	Yrs.	Months	Days	Hours	Min.	Nov 22	y, Year) • 19	29 Mar	yland	
	p ,		Usual Residence of Decedent		10c. City, To									10d. Inside City Limit	
	ehov	5	MD 10a. State 10b. County 10b. County		TOC. City, To	Jur1								1 ☐ Yes 2√ N	
	h the Marylan r 28a-f ehow	Director	10e. Street and Number	Stel		Juli	10f. Zip	Code				10a. Cit	izen of What Co		
	3a or	١٥	203 Broad Street						1643				USA		
	death	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	as Decede			rigin? (Spe	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit		_
٥	or its		1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 No			Yes 2		Specify		ticari, otc.,		Specify: Wh		
215-0036	i 72 hours after death with the Maryland "neturel", or Iteme 23a or 28a-f ehow sidical Examirer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1 40							105 1			
다	22	Completed	15. Decedent's E (Specify only highest gra	ade completed)		Sa. Decede (Give ki life. D(int's Usual ind of work O NOT use	k done c	during mos	st of working	g	16D. K	and of Business	rindustry	
717	within jiene. r then "	E O	Elementary/Secondary (0-12)	College (1-4or 5+))	ma	anage	r				fo	ood indu	ıstry	
and 7	al Hygi other vent, L	Bec	17. Father's Name (First, Middle, Last)					18. Moth	ner's Name	(First, Middle,				
<u>a</u>	should be and Mental amarked umatic ev	To E	Willie James H	Robinson					D	aisy	Mae Pr	itch	nett		
Mar	and and summers		19a. Informant's Name/Relationship (or Town, State,	Zip Code)	
	s 1 end if Health Item 27 other ti		Shirley Robinson 20a. Method of Disposition	n/spouse	20b. Place				eet H		k, MD	216	ocation - City or	Town State	
aitimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Special		ceme	itery, crema	atory or oti	her plac	Θ)			200. L	ocation - only of	Town, State	
Rait	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Lice Ronald S.	Wade Dire	cfor		Name and tate altim			Board 2120	1 655 W	. Ва	altimore	e Street	
			23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	he death. D	o not enter	the mode			Α.				Approximate Interval Between Onset and Death	
£	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence	57 mil.	IVE.	Lu	7	N/	sepse			Syrs	
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289	ficate phys s the	edicai		d											
XOX	eath certific attending pl	υ/Μ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of									23d. Date of de	livery	
S. E	0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2 4□Pregnant at tir 9□Unknown			Ectopic pre Other (spe						Month	Day Year	
 J	law requires that the das been signed by the	by Pr	Part II. Other significant conditions	contributing to death but	not resulting	g in the und	dertyin g ca	ause givi	en in Part	1.	23e. Did to	obacco	use contribute t	o the cause of death?	
202	quire in sig uld bi										780	Yes 2	□No 3□P	robably 4 Unknow	'n
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Ĭ	The late had page	Completed									perto	rmed?	death?	~	
<u>=</u>	cian: ertific octor,	Be (25. Was case referred to medical examiner?							_	(Check only o				
5	Physician: The lav rthis certificate has ral director, page 2	2	1 ☐ Yes 2 No	Hospital: 1 Impatient 28a. Date of Injury									6 ☐ Other (Spe	ecify)	
	Jing J After funer	ion	27. Magner of Death 1 Natural 5 Pending	(Month, Day	Year)	b. Time of Injury	м 28	8c. Injun Worl	yat k? Yes 2.⊑		.8d. Describe h	now inju	iry occurred		
DIVISION	death ctor: / the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	De Place of Injus	y - At home, (Specify)	, farm, stree			100 22		8f. Location (S City or Tov	Street a. vn, Stat	nd Number or R e)	lural Route Number,	
	To the Hospital or At within 24 hours aftar or To the Funeral Direct completely filled in by	edical Ce	(Check only & Medical Exa	hysician: To the best of miner: On the basis of e	examination	dge, death	occurred a	at the tin	ne, date a	and place, a	and due to the	cause(s	s) and manner a d place, and du	s stated. e to the cause(s)	_
	the thin 2 the mplet	Med	one) 29b Signature and title of certifier	and manner state	ed.				e number				ate signed (Mon		
)	Z w Z		125	////										,	
			30. Name and address of person who	completed ause of dea	ath (Item 23)	a) (Tvon. P	Print)	~ "		210		-	16	1802	
			Donate Court in	1 : 1	HUSDIE	2 A	0. B	Pox/	733	S	olish	. 1	415 7	1802	
No.	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature		- 6				0)			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ROHR JR. ALEXANDEN 1112 AM FEBRUATY 6 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore City Johns Hopkins Hospital at Bayview Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min txSxM 2□F Yrs. MĎ Director 213-26-5851 8-8-1929 76 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Millersville Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 799 Springdale Drive 21108 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mentai Hygiene. Introduce them 27 le marked other than "natural", or lean any injury or other traumatic event, the Medical Ferral PAGE. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 A Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Maryland State Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander B. Rohr, Sr. Rose M. Desantis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Rohr / son 799 Springdale Drive; Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ZCremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Chesapeake Cremation 2-10-2006 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 W1120 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician intracvanial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed chronic Box 68760.72 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 this certificate has been signed by all director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 Perobably 4 □Unknown Be Completed 24a. Was an autopsy performed? After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Hapatient 1 ☐ Yes ZZNo Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 M.D. 2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Bultmin wolfe 600 とって ANDUDE JAINAG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 9 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03683 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Roberts 01 23 Trane 2006 Janice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Maryland Medical Center Baltimore University Baltimore 7. Age (fn yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F Director 19 Jan 23, 2006 Maryland none
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD 17 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Haelith end Mentel Hygiene. Important: If frem 27 is marked other than "natures" any injury or other traumatic averages. Funeral (1328 W. Lanvale Street 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: \$ Specify: black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Victor Roberts Tricia Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Medical Ctr 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Funetal Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical extreme prematurity Examiner Be Completed by Physician/Medical Examiner labor or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown holoprosencephaly, multiple renal cysts 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? massive ascites, club feet 2LING 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 29a. Certifier (Check only one) I wentitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

31. Date fited (Month, Day, Year)

22 S. Greene St 82. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Baltimore, MD

			1 - For State Registrar	State of Ma	ıryland		artment of H			giene)6 0	3684
	100 T		Decedent's Name (First, Middle, La	ist)					2. Date of De	ath	Y 3.	Time of Death
	Physici /Medic		ALBERT			RAIN	1		FEBRU	ARY^{Day} 5, 2	2006 10	0:30 P ™
) 8	Examin	er	4a. Facility Name (If not institution, gir SUNRISE ASSISTE				4b. City, Town, o	ALTIMOR		4c. Count	y of Death BALT]	IMODE
-	Funeral				(In yrs. la	st birthday)	If Under 1 Year	If Under 24 h	Irs. 8 Date of Bit	rth		(State or Foreign
	Director		216-12-9033	1 M 2 F	84	Yrs.	Months Days	Hours M	SEP. 13	, 1921	Country)	MD
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	eation				10d	Inside City Limits
	Mary!	tor	MD N	/A		TIMOR						1 V Yes 2 □ No
	172 hours after death with the Maryland "natural", or itema 23a or 28a-1 ehow coloni Estaminar mast be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
	ath will		6317 PARK HEIGH	rs avenue #	307			2121			U	ISA
	er des itema	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 XYes 2 N		T 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	o- 14. Ra Bla	ce - American li ick, White, etc.	ndian,
2000	urs aft	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	O MMI.	1	1 ☐ Yes 2 💢 No	Specify:		Specia	fy: W	HITE
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7		mple	Elementary/Secondary (0-12)	College (1-4or 5-		life.	DO NOT use retired UTIVE	d)	working.	11 5 6	OVERNME	NT
7 0	Hygi Hygi ther ant,	e Co	17. Father's Name (First, Middle, Las	t)	4	EVEC	OIIVE	18. Mother's	Name (First, Middle			.1\(\bar{1}\)
a	9 to 20 to	To Be	DAVID			RAIM	1	RACH		,		ELDMAN
ary	and Manual Surmat	 	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number of	Rural Route Numb	er, City or Town	, State, Zip Coo	de)
e G	and 2 ealth m 27 i			VIFE				IGHTS A	VENUE #30			
2	permit. Pages 1 and 2 should Depertment of Health and Mer Important: if Item 27 is marke any injury or othar traumatic 800.8.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 (Cer	metery, cre	sition (Name of matory or other place		Date		- City or Town,	
	permit. Page Depertment Important: if any injury or ance.		4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice		CHIZ		UNO ARLI Name and Addre		/8/2006 SOL LEVII		IMORE,	
Ď	Deperment of the population of		Seath M.	Gettler					N ROAD -		-	
H			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each lin	the death.	Do not ent	er the mode of dyir	ng, such as care	diac or respiratory a		Apr	proximate erval Between
)	Physician		Immediate Cause (Final disease or condition	_ a.			De her	nFG			On	set and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):	De men Seizve 3,650	1 di	Indo			
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a conseque	ence of):	* /	1 001	Pracy 11			
	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c			07656	tes h	(llity			
Ċ.	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last	Due to (or as a	a conseque	ence of):						
09/90	physicate t	dlcal		d								
XOD	w requires thet the deeth certifi been signed by the attending i should be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan		-			23d. Da	ate of delivery	
	deeth	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			☐Ectopic pregnancy ☐ Other (specify) _	У		М	onth Day	/ Year
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g,	signe d be d	1 by	Part II. Other significant conditions	contributing to death bu	it not resui	ting in the u	nderlying cause giv	ren in Paπ I.		tobacco use cor Yes 2 ☑ No	3 ∏ Probably	
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N I I		Bec	25. Was case referred to medical examiner?					26. Place of	1 ☐ Yes Death (Check only	, -	163 26	7140
0	ding Physician: h. After this certific funeral director,	ို	1 ☐ Yes 2 No	Hospital:		R/Outpatie		Nursin	ng Home 5 ☐ Res			
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VISION	Attending r death. sector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of Inju			reet, factory, office			(Street and Num	ber or Rural Ro	oute Number,
5	talor rs efte al Dir	Cert		building, etc						wn, State)		
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Sertifying P (Check only one) 2 Medical Exa	hysician: To the best of minar: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurred at the til vestigation, in my o	me, date and pl opinion, death o	lace, and due to the occurred at the time	cause(s) and m , date and place	nanner as stated , and due to the	d. cause(s)
)	Withir To the comp	×	29b. Signature and title of dertifier	Wi	\mathcal{N}		29c. Licens	nedmun es	0329	29d. Date sign	ed (Month, Day	Year)
	8		36 Name and addless of pelson who	completed cause of de	eath (Item	23a) (Type.	gint) o Cd	Cont	nd, D	MEN	PR, 7.	DULLES

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 9 2006

State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 6 2006 ear Lloyd H. Rupp 9:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Long View Nursing Home Carroll Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 1997 1997 4 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F Maryland 91 218-34-1651 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examinat must be notified at once. 10d. Inside City Limits Carroll Millers Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4248 Rupp Road U.S.A. 21107 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Rupp Minnie Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10849 Donelson Dr. Williamsport, Md. Mary Kroll/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Lineboro Cemetery 2/10/06 Lineboro, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, 21. Signature of Funeral Service Licensee 3296 Charmil Drive, Manchester, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Packinsonism Physician /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 ☐ Yes 2 No 2X No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number about Mys mo 0051705 2-7-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster MD 21157 349 PANSURIPA wolvolo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#/,perfH,382,2/2/06 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12308 M 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore 105 DITE Memoria ION If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months Days Hours 219-30-479 Usual Residence of Decedent Yrs. Director Mar 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic event, the Modical Exercicer must be notified at 1 Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral death Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. adary (0-12) College (1-4or 5+) 's Name (First, Middle, Last) 18. Mother's Name Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 € if of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. 7-15-06 Balto. 21. Signature of Funeral Service Licensee Services Free Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) WIMONDRY Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) for use as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed CAT that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physicien RENAL DISEASE Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signe funeral director, page 2 should be 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an of rmed? 2 🖸 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 4 Nursing Home 5 Residence 6 Other (Specify Out of Discussion ٩ 1 ☐ Yes 2 V No 2 ER/Outpatient 3□ DOA 27. Many r of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Watural Injury nours efter death. neral Diractor: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours et To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of confrier 29d. Date signed (Month, Day, Year) 2000 KU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21278 Baltmare (HO) 201 E. BANKWAY UNIVERSITY 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State 9 2008 FEB 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🔓 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 9:00A M January 23, 2006 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MOIL If Under 24 Hrs. Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□F Months 225-26-9661 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Never Married 2 Married 1 ☐ Yes YNo Specify. f Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry opndary (0-12) College (1-4or 5+) ver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heelth at Important: If Item 27 ie any njury or other trau Balto MD 705€ 10 22 S 20c. Location - City or Town, State daughter 201. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State Date M+Zion Cemeter 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ene Freezal Ser FOLK Rd Balto ND 23a. Part1. Differ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure Buseks Renal /Medical Due to (or as a consequence of): Examiner Cardiomyopatu End Stage
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 \ No 1 ☐ Yes 200 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury

Box 68760,

attending physicien and for use as the burial-transit

ete hes been signed by the page 2 should be detached

rthen "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

2 should be for and Mentel F

P.O. Records, Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State

Medical

2 Accident 3 Suicide

4 - Homicide

29b. Signature and title of certifier

nienyenwa 31. Date filed (Morth, Pay, 9-2006

29a. Certifier

6 Could not be determined

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

wachinemer

32 Registrar's Strinature

and manner stated

KO Dwachinemer & M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Memorial Hospital MD.

			1 - State Registrar	State of Maryla		artment of H			ene 0 0 6	03688
			Decedent's Name (First, Middle, Las	st)				2. Date of Death	1	3. Time of Death
н	Physici		Edwin Patrick S	mith				Month February	Day Yea 2 2006	4:03 PM M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death	rebruary	4c. County of De	
		•	Joseph Richey H	ospice		Baltim	ore			
	Funeral		Social Security Number 6. Security Number		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(9. E	Birthplace (State or Foreign Country)
П	Director		217-30-3333	RM 2□ F 70	O Yrs.	Months	Hours Will.	Mar 5, 1		rginia
	pu »		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	eation				10d. Inside City Limits
	eho.	5	MD Anne Arr			n Burnie				1 ☐ Yes 2 ☑ No
und	the M	ect	10e. Street and Number	under	GTE	10f. Zip Code		10	g. Citizen of What	
B	deeth with the Maryland me 23a or 28a-f ehow rinust be notified at	급								Southly:
R	ne 23	era	306 Ferndale Av	enue 12. Was Decedent Ever in	U.S. 13. 1	Was Decedent of H)6] Ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ar	merican Indian.
Maryland 21215-0036 5	urs after d N', or iten	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 153		f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wi Specify: W	hite, etc.
ğ	2 ho	Completed	15. Decedent's Ed	lucation	16a. Deced	dent's Usual Occup	ation	1	6b. Kind of Busine:	ss/Industry
2	thin 7	pje	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	ang		
7	or th	io l	12	2	welfa	re inves	tigation		social se	rvices
ם	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u>Na</u>	Ment Ment arked	은	Frank Meredith Sm	ith			Anne L	ee Kraus	e	
a	2 shc and ie m		19a. Informant's Name/Relationship (7	•					City or Town, State	
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23s or 28s f show apprintury or other treumatic event, It is Medical Exactinate mast be notified at ODEs.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	 Place of Dispo cemetery, crer 	sition (Name of natory or other plac	ce)	Date 2	Oc. Location - City	or Town, State
Balt	permit. Depertimon import		21. Signature of Funeral Service Licen Ronald S.	see Wade/Directo	or S	Name and Address State Ana altimore	ss of Facility tomy Boar , MD 212		Baltimor	e Street
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	olications that caused the de one cause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	/Medical		resulting in death)	a. COYONAY Due to (or as a cons	quence of):	7				90015
	Examiner		Sequentially list conditions,	b						
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9	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pred	nancy					
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o.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	1 dea(1) 5 L	1 Other (specify)				
<u>a</u>	res that tigned by	유	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Division of Vital Records,	8 6 6	d by						1 □ Ye	s 2 □No 3 □	Probably 4 Onknown
Ö	w require been si should I	Completed						24a. Was an	24h Were	autopsy findings available
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Ē	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2. No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	05		nce 6 Other (S)	Hospica
ō	Phys er this eral di		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	y at	28d. Describe how		becity) (19pice
<u>o</u>	nding th. :: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,) Injury	M 1	Yes 2 □No			
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á	al or s efte il Dir od in l	Certification:	4 ☐ HOITICIDA	building, etc. (Spe	эсіту)			City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours etter deeth. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my lander: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
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			77/40 MD			Di	24170	F	Ebruary 2	2006
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)		•	1	,
			E.TsoMD Rich	ey Hospice 8	38 N.E	utan St	Balti	more, h	February 3 1D 2126	o i
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	Registr	ar	EFR 0 9 200	6 32		Sandy T				

			1 - For State Registrar	State of Maryland		artment of H			ene 1. No. 0 0 6	03689
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		ELIZABETH	SMITH				Month 0/	Day Year	5:40 A M
	Examin		4a. Facility Name (If not institution, give st.			4b. City, Town, or			4c. County of Dea	th
			GENESIS RAND	ALLSTOWN		RANDA	LLSTON	72	BALTI	MURE
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	"	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear) 9. Bir	thplace (State or Foreign
	Director		238-36-6649	M 2√ F 83	Yrs.			Aug 6, 1		th CArolina
pue	. ≱		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Asizi	e B	5								1 ☐ Yes 2 ☑ No
the A	28a	ect	MD Baltimo	re	kanda.	10f. Zip Code		100	. Citizen of What Co	
E S	o ad	<u>=</u>	9109 Liberty Road				.133	105	USA	yarisi y .
deeth	78 27 E	Funeral Director		2. Was Decedent Ever in U.S	S. 13. V			Specify Yes or No-	14. Race - Ame	erican Indian,
fier	riter	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Whit	
		ð	3 ₹ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2🌠 No	Specify:		Specify: b1a	ıck
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d be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23s or 28s of show any injury or other treumatic event, it a Medical Exacting must be notified at once.	o Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle, Ma	uden Sumame)	unk
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- ע	f He item		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of natory or other place			c. Location - City or	
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	orte Porte		21. Signature of Funeral Service Licensee Ronald S. W.	in state	22	. Name and Addres	ss of Facility	d 655 W. 1		
ă	Depa impo any ir		Ronald S. W.	ade Viroctor		ate Anat Itimore,			Baltimore	Street
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death.			The state of the s		t,	Approximate Interval Between
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The law requires that the death certificate	been signed by the attending p		Part II. Other significant conditions conti	ributing to death but not resul	Iting in the ur	ideriving cause givi	en in Part I	23e. Did toba	cco use contribule lo	the cause of death?
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	has le 2 s	Completed	17FE IL DIAG	ZETES MER	-L17 U	2		24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
<u> </u>	icate 7. pag							1 ☐ Yes 2 Î		2 🗆 No
VIC	certif	Be	25. Was case referred to medical examiner?	spital:		Oth		ath (Check only one)		
5 4	this al dii	To	1 ☐ Yes 2 ☑ No	1 Inpatient 2 E	R/Outpation 28b. Time of	t 3 DOA 28c. Injun		forme 5 Resident		cify)
	feath. tor: After this certificate has the funeral director, page 2	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 □ No	200. Describe now	injury occurred	
	deatl ctor: y the	Ical	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne farm stre		103 2010	28f Location (Stre	et and Number or Ru	ural Route Number
	after Dire	ertification;	4 Homicide determined	building, etc. (Specify))	out, ractory, cinica		City or Town,	State)	
spite	nere nerel	aic	29a. Certifier 1 Certifying Physi	cian: To the best of my know	viedge, death	occurred at the tin	ne, date and place	e, and due to the cau	se(s) and manner as	stated.
To the Hospitel or Attending Physicien:	within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical	(Check only 2 Medical Examine one)	er: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	pinion, death occu	irred at the time, date	and place, and due	to the cause(s)
Tot	Tot Eog	Σ	29b. Signature and title of certifier			29c. License			I. Date signed (Mont	
			Dim mid			Dos	59107	0	12-03-	2006
			30. Name and address of person who corr							
			KALU UMA 26	7		nTS AVE	NUE B	ALTMORE	mo 21	215
	Sta	ite	31. Date filed (Month Day, Year) 2006	32. Registrar's Signat	ure F	and the same				

Regina	ald Spe 869	nc	er Tyler, Jr Please Type or Print in Black Indelible In	ık. Ensure Al	l Copies A	re Legible.	00000
crn			State of Maryland / Department of State of Maryland / Department of Certificate of Certificate	f Health and M	lental Hygi	ene 6 g. No.	03690
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Reginald Spencer Tyler, Jr.		2. Date of Death Month February	y 04, 2006	3. Time of Death 4:20 A M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death		4c. County of Deat Prince G	
	Funeral Director		5. Social Security Number 6. Sex 1216-04-8090 1. Sex 122 F 37 1. Age (In yrs. last birthday) Months Day	ear If Under 24 Hrs.	8. Date of Birth (Month, Day, 1) Feb 8, 1	Year) 9. Birt	hplace (State or Foreign buntry) hington, DC
	death with the Maryland ms 23s or 28a-f show chrunt be notified at	ctor	Usual Residence of Decedent				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number 10f. Zip Cod.		109	g. Citizen of What Co	untry?
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9600	nours after are!, or ite	by	Armed Forces? 1S Never Married 2 Married 1 Mar	Cuban, Mexican, Puèrto I No <i>Specity:</i>	Rican, etc.)	Black, White	
Maryland 21215-0036	within 72 h ine. ihen "natu n Medica	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ne during most of workir tired)	ng 16	6b. Kind of Business/	
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/lan	uid be Mental irked tic ev	To Be	Reginald Spencer Tyler, Sr.	Barbara I			
Aary	2 sho	1	19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street	eet and Number or Rura	l Route Number, (City or Town, State, 2	(ip Code)
Baltimore, N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if them 27 is marked other than "naturel, or thems 23s or 28s-1 show any injury or other traumatic event, it is Medical Examinating must be notified at ODEs.		Reginald Spencer Tylor, Sr. 6609 Jeffers 20a. Method of Disposition 1 5 Burial 2 Cremation 3 Removal from State Sylvanian Bantie	place)	ate 20	Oc. Location - City or	Town, State
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Vits:	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ FR/Outpatient 3 □ DOA	26. Place of Death Other:	7.7 T. T. T.		at gaana
י ס	g Phys ter this neral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. In	4 Nuising Hon	ne 5 Residen 28d. Describe how	ce 6 Other (Spec	myat scene
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours attendeath. To the Funeral Director: After this completely filled in by the funeral di	Certification:		Yes 2 No	City or Town,	et and Number or Ru	In Callinga Tral Route Number,
	e Hospital 24 hours • Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the axis of examination and/or investigation, in my and manner stated.	e time, date and place, a sy opinion, death occurre	and due to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To th Within To th compi	Me	29b. Signature and title of certifier 29c. Lice	ense number		d. Date signed (Mont bruary 04	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE MITTERS M. D. 1111 Penn Street	et, Baltimo	re, Mary	land 21201	L
4	Sta Registr		31. Date filed (Month Daz (1919) Registrar's Stofature				

			1 - For State Registrar	State of Ma			rtmen tificate			and M		Reg. No	UUD		369	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Robert Taylor Sr.								2. Date of D Month Feb.	07 ^{Da}	200	06	3. Time of Dear	th M
	Examin	er	4a. Facility Name (If not institution, give Saint Agnes Hospi	tal			Balt	imor.					. County of D			
·	Funeral Director		5. Social Security Number 217–24–4331 6. Social Residence of Decedent	ex 7. Age MM 2□ F	9 (In yrs. last birtl 78 Y	rs.	If Under Months	Days	If Under a	Min.	8. Date of B (Month, D 06/20,	av. Year)		Countr	more, M.	
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	th with the 23a or 28	ai Director	10e. Street and Number 715 Maiden Choice	Lane			10f. Zip 212					10g. Ci	tizen of What	Countr	•	
036	be filed within 72 hours after death with the Maryland tal Hygiene. A hours after death with the hadrest or Items 23s or 28s-f show avent, the Madrest Examinal most be notified.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Worvorced	12. Was Decedent I Armed Forces? 11☑Yes 2☐N If Yes, Give Year or Dates:]	lo		Vas Deced Yes, spec		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - A Black, W Specify:		ic.	
21215-0036	d within 72 ho jiene. r than "natur	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	+)	(Give I	OO NOT us	k done d e retired	during most		ng	JN	ind of Busine Normand Lines	d Ge		
	should be filed nd Mental Hygis markad other umatic avent, II	To Be C	17. Father's Name (First, Middle, Last) Edgar Taylor		'				Mary	Eliz	(First, Midd) zabeth	Hurl	.ey			
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Division of Vital Records,	ittending I death. ctor: After y the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Inju	Year) In	njury	М		/ at ⟨? Yes 2 □ I	No		(Street ar	nd Number o	r Rural	Route Number,	
ā	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in by	edical Cert	29a. Certifier 1 Tertifying Ph	building, etc ysician: To the best on niner: On the basis of	of my knowledge.	, death	occurred	at the tim	ne, date an	d place,	and due to th	e cause(s) and manner	r as sta	ted.	
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	10		30. Name and address of person who Jyothi Punnam,	completed cause of d 900 Caton			,	ore.	MD	212	229					
A	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	المنع										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Joseph G. White, Sr. February 5, 2006 5:05 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner Ivy Hall Geriatric & Rehab Ctr. Middle River Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days Hours 1 ☑ M 2 ☐ F Yrs. Director 82 14,1924 Maryland 216-20-1095 Jan. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23e or 28a-f show Exemple raust be notified at 1 ☐ Yes 2 No Maryland <u>Baltimore</u> Dundalk Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: if than 27 is marked other than "network any injury or other traumation." 7804 Kavanagh Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ho If Yes, Give Year or Dates: Specify: White WWIT þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Classification Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Hinkle ဥ William White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7804 Kavanagh Road Dundalk, Maryland Mr. William White (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 Other (Specify)

21. Signature of Juneral Service Licensee 2/9/2006 Glen Burnie, MD Glen Haven Cemetery 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) by the a I Yes 2 □ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Ursing Home 5 Residence 6 Other (Specify) Medical Certification; To this 27. Manner Leath 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 🗀 Homicide To the Hospital filled within 24 hours To the Funeral 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26,perMD 3852,2/9/06 TT

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Ezra David Wile February 4, 2006 9:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 511 East Broadway Harford Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours XXM 2 F Director Yrs 95 212-36-5466 Feb. 7,1910 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√XNo Bel Air Directo Maryland Harford Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21014 United States 511 East Broadway 238 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 'natural', or Itame Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XIXYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United States Army 8 Years Sergeant Major other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lipity or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Little Charles E. Wile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 East Broadway Bel Air, Maryland Mr. David E. Wile (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sagred Ht. of Jesus Cem. 2/7/2006 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu re al Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ARRHYDMIA SERONDS /Medical Due to (or as a consequence of) Examiner 770 CANSIAL for FAR UTION コレンノフ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o the 9 Unknown 9 Unknown ል Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RECU 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: : After this certification and funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 🗷 No ٩ 3 DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after o To the Funeral Direct completely filled in by 4 Homicide npletely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 133088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Birnbaum 1321 Riverside Pkwy Belcamp, Maryland 21017 31. Date filed (Month, Day, Year) FEB 0 9 32 Registrar's Signature State 2006 Registrar

		•	1 - State of Maryland		artment of H			giene	03694
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physicia	_	Margaret Jeanette	. Wa	rd		Februar	y 7, 2006	11:50 A ^M
1	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of Dear	
	LAGITIII		St. Agnes Hospital		Baltimo	ore		N/A	
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	-	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	r. Year) Co	hplace (State or Foreign ountry)
	Director		214-01-2387 89	Yrs.			JUL 4,	1916 Ma	ryland
	and		10a. State 10b. County 10c. City, T	own or Lo	ocation				10d. Inside City Limits
	Mary feb	ō	Maryland Baltimore		Caton	sville			1 Tes 2 No
	r 28a	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	3a o	O E	707 Maiden Choice Lane, Apt. 620	1	21228			USA	
	deati	ner	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
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lan	0 = 0 =	To Be	George Vernon Iglehart			Mazie	e Earl Mi	lls	
Maryland 21215-0036	s 1 and 2 should 1 Health and Mer item 27 is marke other traumatic	_						r, City or Town, State,	
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Bal	permit. Pag Department Important: I eny injury o		Zolumet Should					ore, MD 21	
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	thin 2 the 1 mplet	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Moi	nth, Day, Year)
	¥ ¥ ¥ 8			gal	LA DOOG	20040		February 8	2006
	_		30. Name and address of person who completed cause of death (Item 2	3a) (Tuni		20040		repruary o	, 2000
	12		James Evans, M.D. 711 Maiden			Catonsvi	lle, MD	21228	
13	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		Caille				
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Physic /Med	ical	_	Decedent's Nam	e (First, Middle, L Andre We	ells							2. Date of De Month Janua	eath Da	y 6 20	Year 206	3. Time of Deat 1:35
Exam Funera Directo		5.		appe Road	d Apartmen Sex 7. **X** IM 2 F	nt B Age (In yrs.	. last birthday) Yrs.	Dur	ndalk der 1 Year	If Under 24	Hrs.	8. Date of 8i (Month, D.	rth	altin	nore 9. Birthp	place (State or Fore
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be filed within 72 hours after death with the Maryland tal Hygiene. of other than "nature!, or items 23a or 28e-f show event, the Modical Examinating main the notified at	by Funeral Director	•	Marital Status Never Marr Widowed	ried 2 Married 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es?		If Yes, s	cedent of Hi pecify Cuba	spanic Origin n, Mexican, I Specify:	? (Spec Puerto F	city Yes or N Rican, etc.)	0-		, White,	ean Indian, etc.
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and and lealth m 27				Wells,	Mother	lon.				ynn La	_	Glen .	_	_		
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127.5	ä,	1. Decedent's Name (First, Middle,					2. Date of Dear Month	th Day Ye	3. Time of Death
Physi /Med	ician dical	Nathaneal	Walter	War	ren		Februar		- 'D. A.M
Exam		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of D		4c. County of E	Death
		Battimere Rehabili	totopo + Extended	Care Cent	1	Baltin			
Funera	al		169M 2015	s. last birthday)	If Under 1 Year Months Days		Ain. (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Directo	or	227-16-6084	85	Yrs.			Oct 10,	1920 V	irginia
pue *		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
Aaryll	٥	MD		Balti	more				1 ▼ Yes 2 No
the 1 28a-	Director	10e. Street and Number		Daron	10f. Zip Code		1	0g. Citizen of What	t Country?
with a or	0					000			
Jeath The 2;	Funeral	1706 A Guilford 11. Marital Status	12. Was Decedent Ever in	U.S. 13.		202 Hispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)	USA 14. Race - A	American Indian,
if the red	교	1 Never Married 2 Marrie					uerto Rican, etc.)	Black, V	Vhite, etc.
hours af	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates: 142-	-45	1 ☐ Yes 2 💢 No	Specify:		Specify:	black
72 hours after death with the Maryland nature!; or Items 23s or 28s-f ehow alsel Examinat he notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of	working unk	16b. Kind of Busine	ess/Industry unk
within iene. then "	npjdu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
ygier ygier tt.	ပိ	12	0						
id be fill lental H ked oth	Be	17. Father's Name (First, Middle, La					Name (First, Middle, I	Maiden Sumame)	
should be filed within and Mental Hygiene. marked other then "umatic event, the Man	ုင	Willie Lee V					a Johnson		
d 2 sh th and th m T le m traum		19a. Informant's Name/Relationshi					r Rural Route Number		te, Zip Code)
1 and 1 ealth 1 m 27 ther to		VAMC Extended Ca			Loch Rar position (Name of	ven Blv	d Baltimor	e MD 21	L218
Pages nent of hint: If Ite		1 Burial 2 Cremation 3		cemetery, cre	matory or other pla	сө)	Date	200. Location - Oily	or rown, state
mit. Pages pertment of portant: If It		4 ☑Donation 5 ☐Other (Spe					_		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of 1 and 2 should be filed within 72 hours after death with the Marylan Department; if I term 27 is marked other then "nature!", or iteme 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at	Suc	21. Signature of Funeral Service Li Ronal d S	. Wade Mrect	or S	tate Anat altimore,		ard 655 W.	Baltimor	e Street
14		23a. Part 1 Enter the disease, or c	omplications that caused the de					est,	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition		. 11.	C		-		Onset and Death
/Medica	al	resulting in death)	a. Due to (or as a conse	equence of):	7	CINEM			Windital
Examine	er	Sequentially list conditions,	h ·						
D ==	ner	cause. Enter Underlying	Due to (or as a const	equanes of):					
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ate be exemple and the burial-	Ä	resulting in death) Last	Due to (or as a conse	equence of):					
ate b hysic the b	dical		d						
eath certificate be executed attending physicien and for use as the burial-transit	Med	IF FEMALE:							
death ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	ital death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
0 0	ls /s	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	ideath 5L	Other (specify) _				,
requires that the de been signed by the a hould be detached f		Part II. Dther significant condition	s contributing to death but not re	esulting in the u	inderlying cause an	en in Part I	23e Did to	hacco use contribut	te to the cause of death?
ires ti signe	<u>6</u>	Partition and and and condition	s contributing to death but not re	asalting in the c	indenying cause giv	on area.	1 🗆 Y	_	Probably 4 Unknown
w requires been sign should be	etec						-		•
2 2 2	Completed						24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
ate pa	ပိ	4.4.4					perform 1 ☐ Yes	med? deat 2 No 1 □	
Physician: The raths certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital		104		Death (Check only on		
hysi this c	은	1 Yes 2 No	Hospital: 1 Inpatient 2		III JUDOA		ng Home 5 Reside		Specify)
ding Phys n. After this funeral di	lo lo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe no	ow injury occurred	
ttend death tor:	Cat	2 Accident investiga 3 Suicide 6 Could no	t be One Blace of leive. At	homo form of		Yes 2□No	29f Location (S	troat and Number o	r Rural Route Number,
or Attending after death. Director: Afte in by the fune	Certification;	4 Homicide determin	ed 28e. Place of Injury - At building, etc. (Spec		reet, ractory, office		City or Town		n Hurar Houte Wuriber,
To the Hospital or Attending within 24 hours effect death. To the Funeral Director: After completely filled in by the funer	<u>a</u>	29a. Certifier 1 Certifying	Physician: To the best of my ke	nowledne deal	th occurred at the to	me date and n	lace, and due to the c	ausa(s) and manne	r as stated
Hos 24 hr Fun elely	dica	(Check only 2 Medical En	kaminer: On the basis of examinand manner stated.	nation and/or in	ivestigation, in my	opinion, death o	occurred at the time, d	ate and place, and	due to the cause(s)
o the	Me	29b. Signature and title of certifier	11		29c. Licens	se number	2	9d. Date signed (M	fonth, Day, Year)
- S - 0		100-	Hau	MD	Dog	2550	35	ZICINA	5
		30. Name and address of person w	ho completed cause of death (Its	em 23a) (Tvna	. Print)	J 4 0	35	7 6/00	J
			ho completed cause of death (It	RA	RING	RaH	mo	7171	8
the star s	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	- DIVA	Jennin	711	F 1 6-1	<u> </u>
Regi		FFB 0 9 2	22. Registrar's Sig	F GOOD	المعطاة				

		•	For State Registra AMEND#23epe:		of Marylar BMW,McCo			nt of H		and M	lental F	iygier Reg. i	$\leq U U$	6	03697
			Decedent's Name (First, Middle	, Last)							2. Date of) a	Vaar	3. Time of Death
	Physicia		Lois	Ρ.		Aisenb	erg				Janua	ary 2	8 , 20	00°6	10:01 PM
Į.	/Medic Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City	, Town, or	Location o	of Death		4	lc. County	of Death	
			5401 Westbard	Avenue,	# 912		Be	thesd	a				Mont	gome	ry
	Funeral		5. Social Security Number	6. Sex 1 □ M 2X F	7. Age (In yrs.		If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Yea	ir)	9. Birth	place (State or Foreign ntry)
	Director		210-20-7964		7	7 Yrs.				-166	June		1928	Pen	nsylvania
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside City Limits
	daryli f sho	5	Maryland Montg	omerv		ethesda									1 ∑Yes 2 □ No
	28e-	Director	10e. Street and Number					p Code				10g. (Citizen of V	What Cou	ntry?
	3a or		5401 Westbard A	venue, #	912			0816					J. S.		
	J within 72 hours after death with the Maryland jiene, than *naturel', or Items 23a or 28a-f show the Medical Examinatinust to Indiffed at	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Dece	edent of Hi	spanic Ori	gin? (Sp	ecify Yes or	No-			can Indian,
٥	after or Ite		1 ☐ Never Married 2 ☐ Marri	Armed F	2 N No			_			Ricen, etc.)			k, White,	
2-003p	rel', o	þ	3 ☐ Widowed 4 ☐ Pivorced	If Yes, C Year or	Dates:		1 🗌 Yes	21X No	Specify:				Specify	Wh	ite
ה ה	72 h	Completed	15. Decedent (Specify only highes	s Education	1)	16a. Dece	kind of w	ork done o	<i>lurina</i> mos	t of work	ing	16b.	Kind of Bu	usiness/lr	ndustry
Z	ithin Ne.	훁	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	use retired,)						
N	filed w Hygier other th	S			ears	Exec	cutiv	re Se			· /50 1 10				pital
and	m = 0 5	Be	17. Father's Name (First, Middle, I	_ast/				_			e (First, Mid		en Suman	10)	
3	a Mer Arke	ဥ	Harry Pitnoff			401 14 70		(0)			Goldm			04-4- 7	- 0-4-1 0.1 0.4 0
Z Z	h and		19a. Informant's Name/Relationsh Sondra Lee Aise		Dat										ity, Md
e O	Healt Pm 2		20a, Method of Disposition	inderg -		Place of Dispo			CR Ha		Date	-			own, State
و	8 5 5		1X Burial 2 ☐ Cremation		- Ctoto	cemetery, crei udean l	natory`or	other place				14.1		-	yland
altimore,	rtme rtent njury		* 4 ☐ Donation 5 ☐ Other (S _k 21. Signature of Funeral Service)		J				1		-				
ä	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury peoples treumento a once.		Donald (Day.	tternu	E	lward	Sag	el Fu	nera	l Dir	ecti	on, I	nc.	and 20852
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that		th. Do not ent	er the mo	de of dying	g, such as	cardiac	or respirator	y arrest,	LC, II	агул	Approximate
	70		shock, or heart failure. List												Interval Between Onset and Death
	Ph ysician /Medical		disease or condition resulting in death)	a. Nue t	ctustatic o (or as a consec	Tuence off	cana	er_						- +	12 months
	Examiner				(0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0										•
	_	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury	b. Due t	o (or as a conse	quence of):									
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Ď,	e exe ian ar urial-t		resulting in death) Last	Due t	o (or as a consec	quence of):									
9/9	death certificate be executed e attending physician and ad for use as the burial-transit	dlcai		d											
õ	eath certific attending p	Mec	IF FEMALE:	00. 1/											
ХOЯ	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Fet	aldeath 3		pregnancy						te of deliv onth	rery Day Year
_ 	at the de by the a tached f	/sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐ Pre 9□ Uni	gnant at time of one control of the	death 5L	Other (s	specify)		-		_			
J.	hat the	문	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying	cause dive	en in Part I	 L	23e. D	id tobacc	o use cont	ribute to	the cause of death?
ds,	law requires that as been signed b 2 should be deta	d by	•	•		-	,	3			1	□Yes	2 🛣 No	3 ☐ Pro	babiy 4 Unknown
Ö	w require been si should t	Completed									24a. V	- Mar an	24h	Wora aut	oney findings available
ĕ	o	g E									a	utopsy erformed	?	death?	opsy findings available ompletion of cause of
g	ifclen: Th certificate rector, pag	ပိ	25. Was case referred to medical								1 🗆 Ye		No	1 🗌 Yes	2 No
5	Physiclen: r this certific ral director,	o Be	examiner? 1 Yes 2 No	Hospital	Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	Othe	or.		h <i>(Check or</i> ome 5 % F		€ □O+h	or (Span	(6.1)
ō	g Phys er this eral dir	-	27. Manner of Death		e of Injury onth, Day Year)	28b. Time o		28c. Injun	4 🗆 140	uising ric	28d. Descri				ny)
0	ding th. : Afte	tior	1 ☒ Natural 5 ☐ Pendin 2 ☐ Accident investig		onth, Day Year)	Injury	м		k? Yes 2□	No					
Division of Vital Records,	Attencer death	ifica	3 ☐ Suicide 6 ☐ Could r	100d 288. Pla	ce of Injury - At I	nome, farm, st	reet, facto	ry, office		Ť	28f. Locatio	n (Street	and Numb	er or Rui	ral Route Number,
á	el or s afte il Dire	Certification:	4 Homicide determ	bui	lding, etc. (Speci	ity)					City or	Town, St	a16)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifyin	g Physician: To t	he best of my kn	owledge, deat	h occurre	d at the tim	ne, date ar	nd place,	and due to	the cause	(s) and ma	anner as	stated.
	he Hi in 24 he Fi plete	Medical	(Check only 2 Medical one)	Examiner: On the and ma	nner stated.	ation and/or in	vestigatio	in, in my o	pinion, dea	atn occur	red at the tir				
		Σ	29b. Signature and title of certified		0			9c. License		21		1			, Day, Year)
	8		7 6 jalon	elh P. U	Theaton	M.P.		DC	202			0	1/21/	106	
	~		30. Name and address of person												
			Dr. Elizabe	th P. Wh	eaton 73	30 24th	Str	eet,	N.W.	, Su	ite 7 ,	Was	hingt	on,	D. C. 20037
	Sta Regista		31. Date filed (Month, Day, Year)	6 2006	Registrar's Sign	A A	os ell	1							

		1 - For State Registrar	State of Ma	aryland	•	rtment of H		d Mental F	lygier Reg. i	Z III II II	03698
Physic		1. Decedent's Name (First, Middle, La	st)					2. Date of Month		Day Year	3. Time of Death
Physici /Medi		Julius Akman						Janua	ry 1	9, 2006	12:15 A M
Examir		4a. Facility Name (If not institution, give				4b. City, Town, or				4c. County of Death	
		Hebrew Home o			ington	Roc	kville		Dieth	Montgome	-
Funeral Director		377 03 4227	ex 7. Age		93 Yrs.	Months Days		Hrs. 8. Date of (Month, July	Day, Yea	1912 Pol	place (State or Foreign ntry) and
land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ation					10d. Inside City Limits
Mary 1 sh	to	Maryland Montgon	nery	Che	vy Cha	ıse					1 X Yes 2 ☐ No
h the	lrec	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Cou	ntry?
th wit	a D	8100 Connecticut	Avenue, #	714		20815				U. S. A.	
r dea terms	ner	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. V	/as Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White	
s afte	Ϋ́F	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 【XN If Yes, Give	lo	1	☐ Yes 2[XNo	Specify:			Specify:	White
2-0030 72 hours at natural; or	Completed by Funeral Director	15. Decedent's Ed	Year or Dates:		16a Deced	ent's Usual Occupa	ition		16h	Kind of Business/Ir	ndustry
in 72 n na n na	olete	(Specify only highest gra	ide completed)		(Give l	kind of work done of O NOT use retired,	luring most of	working	100.	Talle of Desiriossin	idustry
I with	E	Elementary/Secondary (0-12)	College (1-4or 5	+)		Merchan	t			Grocer	
other file	Bec	17. Father's Name (First, Middle, Last,	1	,			18. Mother's	Name (First, Mid	dle, Maid	en Sumame)	
Vialio build be file Mental Hy srked oth	10	Morris Akman						de Garbo			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it a Marical Exercition cast be notified at once.	l i	19a. Informant's Name/Relationship (Code) 20315
and and mark		Anne K. Akman - V	√ife ————————————————————————————————————	1	1-1-1-1			100000000000000000000000000000000000000	-	Chevy Cha	
Daillinore, bernit. Pages 1 ar Department of Hea mportant: if item nny injury or othe		20a. Method of Disposition 1	Removal from State			sition (Name of atory or other place		Date	lan.	Location - City or T	
tant: Pa		`4 Donation 5 ☐ Other (Specif	y)	Kir		d Mem. G					, Virginia
DCI Separ Mpor Iny in		21. Signature of Funeral Service Licer	1	,	Da Da	Name and Addres nzansky-	Goldbe	rg Memor	ial	Chapels, le, Maryl	Inc.
- 40- 40		23a. Part1. Enter the disease, or com		the de th	Do not ente	70 Rockv	ille P	ike, Roc	KV11	le, Maryl	and 20852
		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e. O	. Do not sinte	i the mode of dying	g, 52011 a 5 ca1	diac or respirator	y arrest,		Interval Between Onset and Death
Pnysician /Medical	i i	disease or condition resulting in death)				t FAilur	е				l Week
Examiner	1		Due to (or as a Isch			myopathy					
	ē	Sequentially list conditions,	b. Due to (or as ;	a consequ	ence of):						
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
of oU, te be executed ysician and ne burial-transit	Exa	resulting in death) Last	Due to (or as a	a consequ	ence of):						
ate be executed hysician and the burial-transit	Ical		d								
as as a	by Physician/Med	IF FEMALE:									
death cer death cer e attendir	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	death 3 🗆	Ectopic pregnancy				23d. Date of deliv Month	ery Day Year
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of de	eath 5∐	Other (specify)			-		
requires that the	P	Part II. Other significant conditions of	ontributing to death bu	ut not resu	Iting in the un	derlying cause give	en in Part I.	23e. D	id tobacc	o use contribute to	he cause of death?
uires t uires t signe ld be								1	Yes	2 No 3 Pro	oably 4 Unknown
W requ	ompleted								as an	24b. Were aut	opsy findings available
The law the has b	E G							pe	itopsy informed	prior to co	impletion of cause of
VILCI ician: T certificat ector, pe	C	25. Was case referred to medical					26. Place of	1 ☐ Ye Death (Check on		No 1 ☐ Yes	2 140
ysicia ysicia is cer direct	0.0	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatie	nt 2 🗆 I	R/Outpatient	3□ DOA Othe				6 □Other (Speci	(y)
ig Phy ig Phy ier this	i.	27. Manner of Death	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Injury Work	at			jury occurred	
VISIOII Attending er death. rector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	n	, ,			res 2 □ No				
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju- building, etc			et, factory, office			n (Street Town, Sta	and Number or Rur ate)	al Route Number,
ital o		VZ									
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier	nysician: To the best on niner: On the basis of and manner sta	examinat	wiedge, death ion and/or inv	occurred at the time estigation, in my op	e, date and pointion, death o	place, and due to to accurred at the time	ne cause ne, date a	(s) and manner as a and place, and due t	stated. o the cause(s)
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and marries sta			29c. License	number		29d. [Date signed (Month,	Day, Year)
10		Andone +	under	mi	0	D0036	5716		Ja	nuary 19	2006
10		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type I		., 10				
		Andrew Kundrat,					ockvill	le, Maryl	Land	20852	
Sta	ate	31. Date filed (Month, Day, Year)									
Regist	rar	JAN 262	006	1	ure	THE STATE OF THE S					

	•		For State Ragistrar	State of Ma		artment of Heartificate of De		ntal Hygier Reg. i	1000	03699
4	Physici /Medic	al	Decedent's Name (First, Middle, La Joyes Violet	Bowman			-	bruary	Day Year	
	Examir		4a. Fecility Name (If not institution, giv Washington Count	re street and number)		4b. City, Town, or Lo	ocation of Death	,	4c. County of Death	
	Funeral Director	-9 	Social Security Number 6. S		o (In yrs. last birthday,	If Under 1 Year	f Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea oril 9,1	Washir 9. Birth Cou .928 Mary	place (State or Foreign intry) land
poe	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Marvis	f eho	tor		ington	•	ithsburg				1 □Yes 2X No
the the	r 28a	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
th wi	23a c	raiD	12275 Pleasant V	alley Rd.			1783		U.S.	A
5-0036 72 hours after death with the Maryland	ial Hygiene. Id other than "naturel", or liams 23a or 28a-f ehow event. I'm Mydical Exandrar must by nydigied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	eanic Origin? (Specify Mexican, Puerto Rice Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:	
	natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupation kind of work done duri	on ring most of working	16b.	Kind of Business/Ir	ndustry
d 2121	than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired) Seamstres	S		Sportsw	are
מ 22	Hygiene.		17. Father's Name (First, Middle, Last)		18	8. Mother's Name (Fi	rst, Middle, Maid	-	
Maryland		To Be	UnKno	wn			Helen F	laugh		
laryla Spould	and N		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ng Address (Street and	d Number or Rural Ro	oute Number, Cit	y or Town, State, Zi	p Code)
			Priscilla A. Buhr	man (Daugh						
altimore,	Department of H Important: If Ite eny injury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		20b. Place of Disp cometery, cre Pleasant	valley Cem	Feb. 6	. 10	Location - City or T	
	Depar mpor my in		21. Signature of Funeral Service Licer			2. Name and Address of L. Davis	of Facility Funeral Ho	MII €→	5 Bradbur	-
979			23a. Part1. Enter the disease, or com		the death. Do not en	ter the mode of dving.	such as cardiac or re		hsburg,Md	Approximate Interval Between
	hysician /Medical xaminer		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Adent	a consequence of):	na of	Ne esop	hagu	٤	Interval Between Onset and Death
58760, A	physician and s the burial-transit	ai Examiner	Securitistly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
. Box (e attending id for use a	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	rery Day Year
dS, P.	signed by	by	Part II. Other significant conditions of	contributing to death b	ut not resulting in the o	inderlying cause given	in Part I.		o use contribute to	
Vital Records, P.O		Completed						24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
Vita	certifi	Be	25. Was case referred to medical examiner?	Hospital:	-8	Other	26. Place of Death (Ca			
DIVISION OF	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y 28b. Time o	of 28c. Injury at Work?	4 Nursing Home	Describe how in		(y)
DIVIS	s after de al Directo ad in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, st c. (Specify)	reet, factory, office	28f.	Location (Street City or Town, St.	and Number or Rui ate)	al Route Number,
Hospii	n 24 hour ne Funera detely fills	edicai (29a. Certifier Check only one) Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the time, ovestigation, in my opin	date and place, and lion, death occurred a	due to the cause it the time, date a	o(s) and manner as and place, and due	stated. to the cause(s)
Tot	To the comp	W	29b. Signature and title of certifier			29c. License n			Date signed (Month,	
	8			am 229	Ill Jut	Print)	Red S	n. thsb	10g N	2006 langland
DHM	Sta Registi 1 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) FEB 0 9 20	A	ar's Signature	W)				

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** January 21, 2006 12:29 p James /Medical Charles Bumgardner

D. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
Under 1 Year | H Under 24 Hrs. Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months t**y** M 2 ☐ F 84 Director 244 22 2654 Jan 5, 1922 North Carolina Usual Residence of Decedent 10d. Inside City Limits daath with the Maryland 10c. City, Town or Location 10a. State 10b. County worde. r than "naturel", or iteme 23s or 28s-f ehov the Medical Extrainer must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11904 New Hampshire Avenue 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filad within 72 hours aftar Yes 2 No f Yes, Give rear or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiena. Sales & Repairs Musical Instruments parmit. Pages 1 and 2 should be file Dapartment of Health and Mantal Hy important: If them 27 is marked otherly of other treumatic event. 17. Father's Name (First, Middle, Last) Sherman Bumgarner Carrie Mae Monday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William E. Bumgardner / Son 1291 Worthington Creek Drive Worthington, Ohio 43085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) George Washington Cem 1/30/2006 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitatines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s tha burial-transit The law requires that the death cartificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Pulmonary Hypertension Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Tes 2 X No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation daath. 2 Accident tha 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifie 29c. License number D0051841 January 24, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Glenn, M.D. 12520 Prosperity Drive Silver Spring, Maryland **2** 6 2006 State Registrar

			For State Registrar	State of	Marylaı		artment rtificate			Mental Hyg	giene)6 (370	0
065		7	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	ıth	Vaar	3. Time of	Death
	hysici: Medic/		Gladys Merit	a Blackwell	1					January	Day 27	2006	1945	Рм
	Examin		4a. Facility Name (If not institution				4b. City, To	own, or Loc	cation of Deat	h	4c. Cour	ity of Death		
1903		- 4	Washington Co	untv Hospi	tal			Hac	perstow	m	Washi	ngton	Count	V
∮ F	uneral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs	last birthday)	If Under 1 Months	Year If	Under 24 Hrs lours Min.	8 Date of Birth	1	9. Birthp	lace (State o try) jinia	r Foreign
Di	rector		229-09-9293	1 M 223 F		92 Yrs.				Sept 6	1913	Vir	jînia	
and	3	1	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside Ci	ity Limits
haryl	o a d	ō		ington		Hage	rstown	ı					1 X Yes	
the	289-	Funeral Director	10e, Street and Number				10f. Zip C	ode			10g. Citizen o	f What Coun	trv?	
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leath	18 22 III	era	333 Mill Stre	12. Was Decede	ent Ever in U	J.S. 13. ¹		21740 nt of Hispa		pecify Yes or No-	14. R	U.S.A ace - Americ		
fter d	본형	Fun	1 Never Married 2 Marr	Armed Force	as?				Mexican, Puer	pecify Yes or No- o Rican, etc.)		lack, White,		
030 urs a	o la	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Oate	es:		1 □ Yes 💥	, No S₁	ipecify:		Spec	oify: Whi	Lte	
21215-0036 ad within 72 hours after death with the Maryland rigiene.	lical	Completed	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usual	Occupation	n ng most of wo	rkina	16b. Kind of	Business/Ind	dustry	
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arylan should be	narke	ဥ	George Olive							Virginia				
Maryland nd 2 should be file Ith and Mental Hy	Taum raum		19a. Informant's Name/Relations		>					ıral Route Numbe				
e, M 1 and 2 Health	am 27		Gladys Marita 20a. Method of Disposition	WIISON (TILE					1 Pike	Hagersto Date	WIN Mar 20c. Location	_		
Baltimore,	Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Exeminar must be notified at once.		1 XBurial 2 ☐ Cremation		110	Place of Dispo cemetery, crer								
tir. Pa	nant	r	4 □Donation 5 □Other (S		Su	ınset C					Christ			
Bal Dermi	any Ir		21. Signature of Funeral Service	Licensee						uglas A.				
_ 40			/ Mustos	y. The	4					N. Hage		_Maryl	and 2' Approximate	
		1	23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on eac	h line.	un. Do not ent		or dying, so		or respiratory arr	est,		interval Bet	ween
0.0	sician	Ì	Immediate Cause (Final disease or condition resulting in death)	a	1	enal								
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ted	nsit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<		ronar	9 0	Liter	4	Diszas	۲.			
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vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath.	hysicien and the burial-transit	cal										İ		
687	G /6			0.										
Box	igned by the attending be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. 0	Date of delive	ry	
Beath De	d for	cia	in the past 12 months?	1 ☐ Live birth	t at time of		Ectopic preg Other (spec				1	Month	Day 1	Year
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y Sici		To B	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 Inp	atient 2	ER/Outpatien	nt 3□ DOA	Other		lome 5 ☐ Resid		ther (Specifi	()	
9 4	- 福		27. Manner of Death	28a. Date of I	Injury Day Year)	28b. Time of	280	. Injury at Work?		28d. Describe h			<u> </u>	
ig ig	r: After e funer	atio	1 Natural 5 Pendin 2 Accident investi	9	Day (dai)	injury .	М		2 🗌 No					
Division of Vital Records, to Attending Physician: The law requires a after death.	by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	uned 289. Place of	Injury - At h	nome, farm, str	eet, factory, o	office		28t. Location (S City or Tow		nber or Rura	Route Num	ber,
Div tal or	ed in	Cer		Danoing.	, 0.0. (0,000.					0.1, 5. 75.1.	, σ.α,			
Division To the Hospital or Attana within 24 hours after deatl	To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifyin	ng Physician: To the be Examiner: On the basi	est of my kn	owledge, death	n occurred at	the time, d	date and place	, and due to the c	ause(s) and	manner as st	ated.	-)
To the H within 24	the F	Medical	one)	and manner	stated.	ation and or in		THIS OPHIO	on, death occu	ined at the time, c	ate and place	s, and due to	1110 Caase(5	,
	1 5	2	29b. Signature and title of certifie											
는 출	5 8						29c. l	License nu	,	- 2	29d. Date sign	ned (Month,	Day, Year)	
To	28			huhu			29c. l	0607	396		01		Day, Year)	
			January 30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,	29c. I	0607	396		01		Day, Year)	
£₹ 5H-3			30. Name and address of person	who completed cause of the second sec	HET)	29c. I	0607	396		01		Day, Year)	
5H-3		te	January 30. Name and address of person	who completed cause of the second sec	HET)	29c. I	0607	396	il col	01		Day, Year)	``

Adrey Jean Buchanan

	•	For State Registrar	State of Mary		partment of F <i>ertificate of</i>			giene Reg. No.	06	03702
o Physicia	an	1. Decedent's Name (First, Middle, Las	,	DIIC	HANAN		2. Date of De Month	ath Day	Year	3. Time of Death
/Medic Examin	al	AUDREY 4a. Facility Name (If not institution, give	JEANNE street and number)	БОС		r Location of Death	Jen	40.0	Zcc (County of Deat	
Examin	-1	Fahrney Kee	dy Memoria		e Ba		(0		Wash	ning for
Funeral Director		5. Social Security Number 6. S 218-24-9980 1	ex 7. Age (In 7. Age (6 Yrs. last birthda	Months Days	Hours Min.	8. Date of Bin (Month, Da JULy	th S, Year)	9. Birt 9. 9 M 8	hplace State or Foreign aryland
and wo		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location					10d. Inside City Limits
Mary B-f sho	tor	Maryland Washi	Ington	Boons	boro					1 Tes 2 No
ith the M or 28a-f	Director	10e. Street and Number	D		10f. Zip Code	4.0		-	en of What Co	-
leath w	Funeral	8507 Maplevill 11. Marital Status	12. Was Decedent Ever	r in U.S. 1	217 3. Was Decedent of H If Yes, specify Cub.		pecify Yes or No		U.S.A 4. Race - Ame	erican Indian,
filed within 72 hours after death with the Maryland Hygiene. Hygiene 1 than "natural", or Items 23a or 28a-f show ant, tre Madical Exertimetrical Letrolified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub. 1 ☐ Yes 2 ☐ XNo	an, Mexican, Puerti	o Rican, etc.)	1	Black, Whit	e, etc. Nhite
natural	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	cedent's Usual Occup ive kind of work done a. DO NOT use retire	pation during most of wor	king	16b. Kin	d of Business	/Industry
withir iene.	ошо	Elementary/Secondary (0-12) 11	College (1-4or 5+)		Homemake				Own Ho	ome
oe filed al Hyg Jotha Ivant,	BeC	17. Father's Name (First, Middle, Last)			_	18. Mother's Nan				
should be nd Mental markad c	P	Claude	Ellsworth		oole ailing Address (Street	Maxin	-	Rhod		Myers
and 2 shealth and m 27 ls n		19a. Informant's Name/Relationship (James S. Buchar			1 Lakewood					
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parmit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natur any injury or other traumatic avent, Ira Madical once.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer	y)	Kest us	22. Name and Addre Andrew K.	1				, Maryland
FOE ES			rady		40 East A	iicteram s	oureet,	пайет	stown,	Mu. 21/40
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/Medical Examiner		resulting in death)	Due to (or as a co							1,00
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To the within To the complete	Me	29b. Signature and title of certifier			29c. Licens			29d. Date	signed (Mont	th, Day, Year)
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H-)		30. Name and address of person who Khalid Wase	em m.D.	1126		r. Hage	rstow.1	mD	. 217	40
Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Ragistrar's	Signature A.	Sparked	J				

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Secretaria Sec	E COLLEGE	Pages 1 ment of H ant: if ita		1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other place)		KI		
Prinysician Medical Statements disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final all conditions shock or condition disease) or condition shock or condition should be condition as a manufacture of the condition of the co		Depart Mport any inj		21. Signature of Funeral Service Licens	M00053						ND 20604
Physician Medical Examiner Physician Medical Examiner				23a. Part1. Enter the disease, or comp	lications that caused the					WALDOKE	Approximate
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29a. Certifier (Check only one) 1 Certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. Name and address of person who completed cause of death (Item 23a) (Type, Print) A SHVINKUMAR PATEL, MD., 603 POST OFFICE RD., WALDORF, MARYLAND 20602	5	ding h. After fune		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury			Describe how in	njury occurred	
29a. Certifier (Check only one) 1 Certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. Name and address of person who completed cause of death (Item 23a) (Type, Print) A SHVINKUMAR PATEL, MD., 603 POST OFFICE RD., WALDORF, MARYLAND 20602	Z Z	tal or Att	Certific	dataminad	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office	28f.	Location (Street City or Town, St	and Number or R ate)	ural Route Number,
B 12:1 D. 44436 JANUARY 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR PATEL, MD., 603 POST OFFICE RD., WALDORF, MARYLAND 20602		he Hospi n 24 hour he Funer pletely fill		(Check only 2 Medical Exami	ner: On the basis of exa	y knowledge, deat mination and/or in	n occurred at the time, divestigation, in my opinion	ate and place, and on, death occurred a	due to the cause t the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A SHVINKUMAR PATEL, MD., 603 POST OFFICE RD., WALDORF, MARYLAND 20602		vith To t		29b. Signature and title of certifier	A		29c. License nun	nber			
ASHVINKUMAR PATEL, MD., 603 POST OFFICE RD., WALDORF, MARYLAND 20602	^			30. Name and antress of person who co	ompleted cause of death	(Item 23a) (Type	Print)	77 26	JA	NUARY 27	, 2006
State Registrar JAN 2 7 2006 State Signature	1	B12:1						LDORF, MA	RYLAND :	20602	
	No.			31. Date filed (Month, Day, Year) JAN 2 7	32. Redistrar's 2006	Signature	Sparke				

Benjamin A. Burkett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06-0616 For State Registrar AKG Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician January 2006 3:23 A Benjamin Adam Burkett /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 45729 Nicholas Court California If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□F 414-53-8288 Director 26 Tennessee April 8, 1979 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28e-1 ehow eny injury or other treumatic event, the Medical Examinar must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏖 No St. Mary's California Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45729 Nicholas Court 20619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Survial Equipment Man U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mark Vincent Burkett Patricia Ann Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10838 Central Pike Mount Juliet TN 37122 Patricia Ann Burkett / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February Cedar Grove Cemetery Lebanon, TN 4 ☐ Donation 5 ☐ Other (Specify) 1, 2006 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. Maden uchaer Teven P.O. Box 270, Leonardtown, MD 20650 Approximate Interval Between Onset and Death Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachyline. Immediate Cause (Final **Physician** 01 10 /Medical resulting in death) Due to (or as a consequence of): Examiner Requestially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□ Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signe should be c 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of a ?

24b. Were autopsy findings available prior to completion of cause of 2 No 24a. Was an hes page 2 autopsy performed? certificete 2 □ No To the Mospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check no one Hospital: 1 Inpatient Other: $4 \square \text{ Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \text{ Mother (Specify) at Scene}$ ဥ 1X Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 25/06 1 Yes 8 Director: A d in by the fo 281. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 uicide 4 Homicide 29 within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

29b. Signature

Por

31. Date filed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland

29d. Date signed (Month, Day, Year)

January 26, 2006

			1 - For State Registrar	State	of Marylar		artment of H		Mental Hyg	iene eg. No.	6 C	3705
		7	Decedent's Name (First, Middle	e, Last)	-				2. Date of Dea	th		3. Time of Death
	Physici /Medic		Aaron	Eugene	Bro	own			Month January	29, 20	Year 06	9:10 a.m.
1	Examin	_	4a. Facility Name (If not institution				4b. City, Town, or	Location of De		4c. County		J. I.O. G. I.I.I.
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	* * *	If Under 1 Year Months Days		in. 8. Date of Birth	Year)	9. Birthpl Count	ace (State or Foreign
0.0	Director		216-12-4374	1 ® M 2□F	89	Yrs.			Sept.19	,1916	Mary	
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits
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	ne 2:	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Was Decedent of H	Ispanic Origin?	(Specify Yes or No-	United 14. Rac	e - America	
(0	r Rec	F	1 Never Married 2 Marr	Armed F	orces? 2 🗌 No	'	f Yes, specify Cuba	in, Mexican, Pu	erto Rican, etc.)		ck, White, e	
21215-0036	el', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2 ₺ No	Specify:		Specify	y: Bla	ck
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7	ed wi	င်	7			Sc	hool Bus					ol Board
nd	d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's N	lame (First, Middle,	Maiden Suman	10)	
Z	Men Men Merke	To.	Arthur Eug		n				ra Isabell			
Maryland	2 sh and is m		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number or	Rural Route Number	, City or Town,	State, Zip	Code)
6	l and lealth im 27 her t		James Brown /	Brother	Jack I		Box 313, sition (Name of	Valley	Lee, Mary			
010	ges 1 if of F if ite		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from		cemetery, crer	natory or other plac	(8)	Date	20c. Location -	City or Tov	wn, State
Ë	tant:		4 Donation 5 Other (S	~	St	. Mark'	s Cemete:	ry Feb	.4,2006 N	/alley	Lee,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if I tem 23 is marked other then "nature!, or iteme 23s or 28s-4 show eny injury or other treumatic event, the Maclical Examinating the notified at once.		21. Signature of Funeral Servi Edward N. Brins	rield, J	r. MO	0052 22	Name and Address Holl	ss of Facility Bywood R	rinsfield oad, Leona	Funera ardtown	1 Home	e, P.A. 20650-0279
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	/Medical		resulting in death)	Due to	(or as a consec	quence of	-0	D V V			- 13	NOTICE OF
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С							-	/
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P.O. Box	The law requires that the deeth certificate has been signed by the attending lage 2 should be detached for use as	iclan/Me	23b. Was decedent pregnant in the past 12 months?	1 □Live	birth 2 Feta	al death 3	Ectopic pregnancy				te of deliver onth	ry Day Year
o	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unkr	nant at time of one	104111 5	Other (specify)		-			
۵.	thet the ded by detail	Physi	Part II. Other significant condition	ons contributing to d	death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
Vital Records,	uires the signed d be del	d by					, ,		1 🗆 Ye	s 2 No	3 Proba	ably 4 Unknown
Sor	w requir been si should	Completed						·	040 1450	045	Man sutas	e diediese e elebie
Re	has ge 2	E D							24a. Was a autops perform	y med?	prior to com death?	sy findings available apletion of cause of
a		e Co	OS Man anno referred to mading						1 ☐ Yes	2 ₽ No	1 ☐ Yes	2 👪 No
5		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital	14	158/0 4	t 30 DOA Oth	er	Death (Check only on			
Division of	Phys r this aral di	\vdash	27. Manner of Death	28a. Date	of fniury	ER/Outpatien 28b. Time of	JUDUA	4 ME IAUIZING	Home 5 Reside)
o	ding th. After funer	ţ	1 Natural 5 Pendin 2 Accident investig	9	nth, Day Year)	Injury		k? Yes 2 □ No		. ,		
NS.	Attendir death.	flca	3 ☐ Suicide 6 ☐ Could I	ined 289. Plac	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St	treet and Numb	er or Rural	Route Number,
á	al or A after I Dire d in by	Certification:	4 Homicide	build	ding, etc. (Speci	fy)			City or Town	n, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kno	owledge, death	occurred at the tin	ne, date and pla	ace, and due to the c	ause(s) and ma	inner as sta	ated.
	n 24 he Fu he Fu	edical	one) 2 Medical	examiner: On the tand mai	basis of examina nner stated.	ation and/or inv	vestigation, in my o	pinion, death or	ccurred at the time, d	ate and place,	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of dertifie	() (1 1		29c. License	e number	2	9d. Date signe	d (Month, E	Day, Year)
,			> Sac	mal 1-1	6210	5 Mal	JD	0641	9	2-1-	-02	3
1	m		30. Name and address f , rson	who completed of	se of death (Iter	m За) (Туре,	Print)		1			
	10			e, M.D.,	24035	Three N	otch Road	d, Holl	ywood, Mar	yland :	20636	
	Sta	- 3	31. Date filed (Month, Day Year)	0 2000	Registrar's Signa	ature	occii Road					
	Registr	ar	FEB 0	2 2006		10 300						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 18 per fh 8852 2-28-06 vt.

State of Maryland / Department of County

For

03706

100		1 = State Registrar		Cei	tificate of	Death	Re	g. No.		00100
Physici	an	Decedent's Name (First, Middle, Las.					2. Date of Death		Year	3. Time of Death
/Medic		MEDFORD B.								4:30 P
Examin	er ~	4a. Facility Name (If not institution, give ANNE ARUNDEL ME	street and number) DICAL CENTER		4b. City, Town,	or Location of Death		ANNE	y of Death	
Funeral Director			7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, JUNE 11,	1 92 5	9. Birth	place (State or Foreig otry) (LAND
within 72 hours after death with the Maryland ane. 19. "Than "netural", or Items 23a or 28a-4 show he Madical Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County QUEEN AN		Town or Lo	cation					10d. Inside City Limit
with the	Director	10e. Street and Number 207 N. CHURCH ST.			10f. Zip Code		10	Og. Citizen of	What Cou	ntry?
eath	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	13 1	21668		pecify Yes or No-	USA 14. Ba	ce - Ameri	can Indian,
ges 1 and 2 should be filed within 72 hours after death with the Marylan to fleatth and Mental Hygiene. It of Health and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	į	f Yes, specify Cul 1 ☐ Yes 2☐ X No	Hispanic Origin? (Span, Mexican, Puerting Specify:	o Rican, etc.)	Bla	ck, White,	etc.
hin 72 ho a. An netur Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of I	Business/Ir	dustry
od with	Som	12	30,1030 (1 40, 51)	ELEC	TRICIAN	,		AUTO M	ANUFA	CTURING
d 2 should be filed within 72 hours at the and Mental Hygiens 17 is marked other than "netural", or traumatic event, the Medical Exam	To Be (17. Father's Name (First, Middle, Last) MEDFORD B. I	BAXTER, SR.				ne (First, Middle, N NDERSON	faiden Suma	me)	
2 should and Men Is marks aumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Number,	City or Town	, State, Zij	o Code)
and 2 salth in 27 I		LOUISE M. BAXTER				H ST., SU		E, MD	2166	8
of He		20a. Method of Disposition 1		ace of Dispo metery, crer	sition (Name of natory or other pla	ace)	Date	20c. Location	- City or T	own, State
Pag nent ant: I		4 Donation 5 Other (Specify	MILF	ORD C	OMMUNITY	CEM. 2-3	-06 N	IILFOR), DE	
permit. Pages 1 a Department of Hea Important: If Item any injury or othe		21. Signature of Funeral Service Licens	la t		. Name and Addr	ONT ST.,	ERRY-SHOP	T FUNI DE 199	ERAL 1	HOME
Certificate be executed ding physicien and ding physicien and se as the burial-transit	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list on attions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	chory .	Ostress	syndie	on e		Interval Batwe
2 2 3	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of decent	death 3	Ectopic pregnand	су			ate of deliv	rery Day Year
uires thet n signed b	d by Pl	Part II. Other significant conditions co		ting in the u	nderlying cause g	iven in Part f.		acco use co	ntnbute to t	the cause of death? bably 4 Junknow
y the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attercompletely filled in by the funeral director, page 2 should be detached for it	Completed	congestive	hoort full	ure			24a. Was an autops perform	n 24b	Were autoprior to codeath?	opsy findings availab ompletion of cause of
nn: rtifica tor, p	BeC	25. Was case referred to medical				26. Place of Dea	ith Check only on			20.10
lysic lis ce direc	ToE	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 patient 2 E	R/Outpatier	t 3 DOA	ther: 4 🗆 Nursing H	ome 5 Reside	nce 6 🗆 O	her (Speci	(y)
Attending Phir death.		27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	W	ury at ork?] Yes 2 No	28d. Describe ho	w injury occu	rred	
al or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of friury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office	,	28f. Location (St. City or Town	reet and Num , State)	ber or Rur	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical C	29a. Certifier Conect only one)	rsicien: To the best of my know iner: On the basis of examinate and manner stated.	rledge, deati on and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	iuse(s) and nate and place	anner as s	stated. to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of pertifie			29c. Licer	nse number	2	d. Date sign	ed (Month,	Day, Year)
		1 921 / the trees	nup.		Do	24804		1-30	-20	06
6		30. Name and address of person who d	ompfeted cause of death (Item			10 /	Lungel	. 11	1 2	1461
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	*	P 24 2		1	2 1000	1	, , , ,

Registrar

FEB 0 9 2006

		1 - State Registrar Ce	ertificate of Death	Reg. No.	U3/U/
Q Dhysici		Decedent's Name (First, Middle, Last)		Date of Death Month Day Ye	3. Time of Death
Physicia /Medic		NEIL MICHAEL CORRIGAN	F	FEBRUARY 3 20	006 6:05p ^M
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of I	Deeth
		Chester River Manor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Chestertown O If Under 1 Year If Under 24 Hrs. 8	Kent	District Charles Control
Funeral Director		5. Social Security Number 6. Sex 199-28-4035 12 M 2 F 7. Age (In yrs. last birthday 70 Yrs.	Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country) EW York
land wo		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Mary I-f sh	ğ	MD Kent Still	Pond		1 ☑ Yes 2 □ No
urs after death with the Marylan al', or Items 23a or 28a-1 show Exteriner must be notified at	I Director	10e. Street and Number 12780 Still Pond Rd.	10f. Zip Code 21667	10g. Citizen of Wha	it Country?
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- 14. Race -	American Indian,
be filed within 72 hours after death with the Maryland Ital Hyglene. to other then "natural", or Items 23a or 28a-f show event, it e Madical Exeminer must be notified at	by	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	White, etc. White
72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Busin	ess/Industry
within ane. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		Denitor	
filed Hygie thar	ပိ	17. Father's Name (First, Middle, Last)	School Art Teac	her High Sc First, Middle, Maiden Sumame)	NOO1
ic eve	To Be	James M. Corrigan	Alice I	nglis	
shou and M mar umat	-		ling Address (Street and Number or Rural F		ite, Zip Code) 2166'7
and 2 alth a 127 le		Doris Corrigan (sister-in-law) 12966 Still Po	nd Rd. Still	Pond, MD.
of He of He fiter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cre	position (Name of Datematory or other place)	te 20c. Location - Cit	y or Town, State
Pag ment ant: J			Pond Cem. 2/10,	/06 Still	Pond, MD.
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", any injury or othar traumatic event, it a Madical Exspace.			22. Name and Address of Facility alena Funeral Ho	me of Stephe	n L. Schaech
		23a. Ranti Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between
Physician		disease or condition MOTOSTOTIC	Remal Coll (arcumo	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):			
CAditille	L.,	Sequentially list conditions, b.			
bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ertificate be executed Jing physician and se as the burial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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ificate g phy as the	Medical				
Attending Physician: The law requires that the death certificate brideath, rideath, rideath, ector. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	Physician/M		□Ectopic pregnancy □ Other (specify)	23d. Date o Month	
s that	by Pł	Pan U Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu	ite to the cause of death?
w require been sig should b	ed b	langertive Alant tou	lui	1 Yes 2 No 3	☐ Probably 4 ☐ Unknown
ne faw requ has been ge 2 shouli	Completed	0			re autopsy findings available or to completion of cause of th?
ician: The lav certificate has rector, page 2	е Со	25. Was case referred to medical	26. Place of Death (i		Yes 200 No
ysicia s cert direct	0 B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatie	Other	o 5 ☐ Residence 6 ☐ Other ((Specify)
ding Phys h. After this funeral di	n: T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	d. Describe how injury occurred	
auth. or: Aff	atlo	2 Accident investigation	M 1 Yes 2 No		
ter de irecto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Street and Number of City or Town, State)	or Rural Route Number,
urs af urs af ural D					
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 € Certifying Physicien: To the best of my knowledge, dea (Check only one) 2 ■ Medicel Exeminer: On the basis of examination and/or i and manner stated.	ith occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause(s) and manner at the time, date and place, and	er as stated. I due to the cause(s)
To t To t	Σ	29b. Signature and title of pertifier	29c. License number	29d. Date signed (A	
			120051786	teb. 6.	2006
12		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	teb. 6. estertown Mi	211 20
CAO	10	Andraw Sterguson to 120 Spe 31. Date filed (Month, Day, Year) 32. Registrar's Signature	enky brigh ch	estertown MI) 911690
Sta Registr		FEB 0 9 2006	r e		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** GOLDIE Ι. CANBY 5:18 TANUARY 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 3/24/1938 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K WEST VIRGINIA 67 236-56-2852 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahow other traumatic avant, the Madical Examinar must be notified at MARTINSBURG WV BERKELEY XXYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code with ō 25401 405 S. LOUISIANA AVENUE USA or itams 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Exempter. Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GENERAL MOTORS Elementary/Secondary (0-12) College (1-4or 5+) UNITIZER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MINNIE F. RICE JAMES L. PITTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS W. CANBY/SPOUSE 405 S. LOUISIANA AVENUE, MARTINSBURG, WV 25402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 X Surial 2 Cremation 3 Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 4 □ Donation 5 □ Other (Specify) 31. 2006 21. Signature of Funeral Service Licensee O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 ²BROWN FUNERAL HOME, P.O. BOX 821 Chaeles ne Blown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT 0075 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed burial-transit attending physicien and Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Drinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 11 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. investigation 2 Accident within 24 hours after deat To the Funerel Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 50061410 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 154-16 LAFFAR 251 EAST ANTI SYED STIZEET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 31 Registrar 2006

			1 - For State Registrar	State of Mary		artment of F			ene	03709
			Decedent's Name (First, Middle, I	1 /				2. Date of Death		3. Time of Death
Н	Physici /Medi		Leslie MOR	ie Corenti	eld			Month	2 7 200	
	Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Deatl	n	4c. County of D	eath
ı			20415 Kings	Crest Blvd.		Hagers	town		Washin	gton County
	Funeral		Social Security Number 6		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		530-66-3788	¹ □ M ² X F 49	Yrs.			Apr. 20,		lew York
	and we		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Many 1 sho	ŏ	Maryland Washin	aton Co	Hagarata	T-770				1 □Yes 2√2 No
	the 28a	rec	Maryland Washin 10e. Street and Number	gton w.	Hagersto	10f. Zip Code		10	g. Citizen of What	: Country?
	3a or	<u></u>	20415 Kings Cre	st Blvd.		21742			U.S.A.	,
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it w Modical Extendition to interest the intiliary at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	Specify:	o Rican, etc.)	Black, W Specify:	/hite, etc.
9	72 ho	Completed	15. Decedent's		16a. Dece	dent's Usual Occup	ation	duine 1	6b. Kind of Busine	White ess/Industry
2	thin 7 e. m. "r	ble	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or wor d)	-)amaono l	Degi denge
7	ar th	Con	12		Homem	aker		L L	ersonai	Residence
5	al Hy al Hy doth	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	
Maryland	Ment Ment arka	O_	Lester Wells				Norma E	verett		
a	2 sho and is ma		19a. Informant's Name/Relationship			ng Address (Street	and Number or Ru	iral Route Number,	City or Town, Stat	e, Zip Code)
	es 1 and 2 of Health a 1 item 27 is r other trau		Henry L. Corenf				Crest Blv	d. Hagers		
altimore,	of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ob. Place of Dispo cemetery, crer	ssition (Name of matory or other plac	ce)	Date 2	0c. Location - City	or Town, State
Ē	Pag ment ant: ury c		`4 □ Donation 5 □ Other (Spe		Smithsbu	rg Cremat	ory Jan.	30, 2006	Smiths	burg, Maryland
Sail	permit Depart Import any in		21. Signature of Funeral Service Lic	ensee 7	22	2. Name and Addres	ss of Facility Do	ouglas A.	Fiery Fu	neral Home
<u> </u>	205 20		/ Leucky	X. Tury	13	31 Easter	n Blvd.	N. Hagers	stown, MD	
Г			23a. Part1. Enter the disease, or co shock, or healt failure. List on	emplications that caused the ly one sause on each line.	death. Do not ent	ter the mode of dyin	ig, such as cardiad	or respiratory arre	st,	Approximate Interval Between
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	/Medical	l i	resulting in death)	Due to (or as a con		3.00				
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	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					55
	ecute and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	mellit					1,2
80,	oe ex cian ourial	E	,	Due to (or as a cor	isaquanca oi):					
8760,	cate be executed physician and the burial-transit	dlcal		d						
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Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 🗆	Fetal death 3	Ectopic pregnancy	•		23d. Date of Month	delivery Day Year
o.	the the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	ordeath 5	Other (specify)				
<u> </u>	that the	P	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I	23e. Did toba	acco use contribute	e to the cause of death?
ds,	sign d be	l by	090	•	,	,				Probably Unknown
Ö	w requir been si should	Completed								
Sec	e law has	ldm						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of
Vital Records,	ding Physician: The h. After this certificate hi funeral director, page								1 🗆 \	
Ž	iciar certif	Be	25. Was case referred to medical examiner?	Hospital:		oth all DOA Oth	or	th (Check only one		
	Phys this al dir	T.	Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatien	11 30 DOX	4 🗆 Nursing H	ome SResider	<u>_</u>	Specify)
Division of	ding F h. After funera	Certification:	Natural 5 ☐ Pending	(Month, Day Yea	ar) Injury	Worl	yat k? Yes 2 □No	28d. Describe how	v injury occurred	
2	ten leati tor: the	cat	2 Accident investigat 3 Suicide 6 Could not	be 200 Place of Injury	At home farm str		163 2 110	28f Location (Str	et and Number of	Rural Route Number,
<u>S</u>	after Direction by	ertit	4 Homicide determine	building, etc. (S		eet, lactory, onlo		City or Town,		riorar riodio realitoer,
	Hospital		29a. Certifier 1 Certifying	Physician: To the best of my	knowledge death	n occurred at the tim	ne date and place	and due to the car	(ca(c) and manna	r ac stated
	- (7 - 70	edical		aminer: On the basis of examiner stated.	mination and/or in	vestigation, in my o	pinion, death occu	rred at the time, dat	e and place, and	due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (M	onth, Day, Year)
	->-0		* XXXX	- FALTO		000	5 KGL		T	7 222/
			30. Name and address of person wh	o completed cause of death	(Item 23a) (Tyne	Print)	00101		Jon 2.	7 2006
31	4-3		Stephen K		Anti-ot-	Strat	+ G965 Hazisti			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature		112/10/1	~		
	Registi		IANGAG	anna A	11 1	ulis				
DH	IMH 17 Rev 1/2	001	UNIX U U Z	NOW PRODUCT	1. july	MAD				

ORIGINAL

			1 - For State Registrar	State of Mary	-	partment of I			iene) () (6 03710
	7		1. Decedent's Name (First, Middle, Last,)				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Mary Lo	u Crab	tree			January		
):	Examin	_	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	h	4c. County of	of Death
		Carlotte .	21680 Pebble B				onardtown			Mary's
	Funeral Director		5. Social Security Number 6. Sec. 109-26-1746	1M 255	yrs. <i>Iast birthd</i> ay 87 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	9. Birthplace (State or Foreign Country)
Ž	4		Usual Residence of Decedent		0/			Jan. 23	, 1919	Alabama
	yland		10a. State 10b. County	100	c. City, Town or i	Location				10d. Inside City Limits
	a-1-e	ctor	Maryland St. M.	ary's	I	Leonardtov	√n			1 ☐ Yes 2 ∰ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?
	ath w		21680 Pebble B	each Court			550		United	
	hours after death with the Maryland turel', or itema 23e or 28e-1 ehow at Examiner must be notified at	Funerai		Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	ipecify Yes or No- to Rican, etc.)		- American Indian, c, White, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ♠ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
21215-0036	hour fure		15. Decedent's Edu	Year or Dates:	16a Dec	edent's Usual Occu	nation		16b. Kind of Bus	siness/Industry
5	in 72 n "nat	Completed	(Specify only highest grad	e completed)	(Giv	re kind of work done DO NOT use retire	during most of wo			,
212	d within giene. rr then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse			Heal	lthcare
	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "naturel", or itema 23e or 28e-1 ehow event, the Medical Extending in mai be notified at	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I	Maiden Sumame	э)
<u>la</u>	Ment Ment prked prked	To	Oscar Blackburn	n			Nao	mi Chadw	ick	
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mai	iling Address (Street	and Number or Ri	ural Route Number	, City or Town, S	State, Zip Code)
	and ealth m 27		Donna R. McCar				Beach Co			n, MD 20650
Ore	ges 1 t of H if ite or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, cr	oosition (Name of ematory or other pla				City or Town, State
Ë	tant:		4 Donation 5 Other (Specify)			ead Cemet				ead, Alabama
Baltimore,	permit. Pages 1 and 2 Department of Health s important: if item 27 is eny injury or other tra		21. Signature of Funeral Service Ocens	10						L Home, P.A.
			Edward N. Brinsfie 23a. Part1. Enter the disease, or compl							MD 20650-0279 Approximate
			shock, or heart failure. List only of	ne cause on each line.	death. Do not e	inter the mode of dyr	ng, such as cardia	c or respiratory arri	531,	Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	NON HODEK		IPHOMA		 		IYRAY
4	Examiner			Due to (or as a co	nsequence of):					
	12 de	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	dementia	A1240	imers				
o	exec an an	Еха	resulting in death) Last	Due to (or as a cor		111101-0				
8760,	cate be executed physician and the burial-transit	dicai		d						
9	n certifica anding ph use as th		IF FEMALE:							
Box	eath certif attending for use as	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1☐Live birth 2☐		□Ectopic pregnanc	у		23d. Date Mon	of delivery oth Day Year
	the a	Physician/Me	1 Yes 2 No	4 Pregnant at time 9 Unknown	of death 5	Other (specify) _			Wildi	an Day Foar
P.O.	law requires that the death certific as been signed by the attending p r 2 should be detached for use as		Part II. Other significant conditions cor	atributing to death but no	t resulting in the	underlying cause or	ven in Part I	23e Did tot	nacco use contri	ibute to the cause of death?
Records,	ires tha signed d be de	Completed by	CORONARY artery	disease		ondonying occord g	on are are n	1 □ Y€	,	3 Probably 4 Unknown
Ö	w requir been si should I	ete		C. SCH SC				24a. Was a	245 14	face a state of findings are labele
Rec	o + 2	m D	hypertension					autops perforr	y p	Vere autopsy findings available rior to completion of cause of eath?
a	ician: Th certificate rector, pag		25. Was case referred to medical				00 Di/D-	1		Yes 22 No
Division of Vital	ding Physician: h. After this certific funeral director,	To Be	examiner?	fospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Ot	205	ath <i>(Check only on</i> Home 5 Z Reside		or (Specific)
ō	g Phy er thii		27. Manner of Death	28a. Date of Injury (Month, Day Yea		of 28c. Inju	ry at	28d. Describe ho		
jo	Attending r death. sector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Morral, Day 166	ar) Injury		Yes 2 □ No			
Vis	if or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s	street, factory, office		28f. Location (St City or Town	reet and Numbers. State)	er or Rural Route Number,
	rs after al Dire	Cer								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa	knowledge, dea mination and/or	ath occurred at the ti	me, date and place opinion, death occi	e, and due to the caurred at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	,	9d Date signed	(Month, Dey, Year)
	No Too		Pollon Office	1. mn		กวง	5411			
			20 Name and address of	acc, 1111).	(Itom 22a) (T	y Print)	シナヤ		Anuary 3	80, 2006
			23511 WILLIAMS	ompleted cause of death St. SULL 10	(ILIGHT 23a) (Type	andtown	MD 206	50		
16.	Sta	te	31. Date filed (Month, Day, Year)	32. Projistrar's S	Signature	gedtown,				
	Registr		JAN 3 U Z	UU3 - 1000	15 1	Goode				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 30 2006 **Physician** Robert Curtis, 9:00am Henry Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min Hours 1**2** M 2□ F 219-12-2876 Director 85 Sept.2, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28e-f ehov Tre Medical Examinar must be notified at 1 ☐ Yes 2 € No Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Wesley Drive, Apt. #103 20646 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Yes 2 No 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mentai Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Civil Service U.S. Government other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mentai George Curtis Jane Cutch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Essie Shorter / Daughter 2222 Olson Street, Temple Hills, Maryland 20748 item men 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
important: If iter
eny injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 2-7-2006 Cheltenham, Maryland Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Pulmory Onset and Death Immediate Cause (Final Chrone **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery for u 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physicisn: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Anatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30/2006 D-52289 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALIN MATHUR MD 10 ST PATRICKS DRIVE STE404 WALDORF MARYLAND 20603

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 2 2006

Maryland 21215-0036

Baltimore,

P.O. |

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UUb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2010 18 2006 REBA MARGARET JANUARY CHANCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HUSPITAL EASTON MEMORIAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Months Days Hours 213-01-5663 Director 90 SEPT.10,1915 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle r than "natural" or Items 23a or 28s-1 shov the Medical Examiner out be notified at MD TALBOT **EASTON** 1X Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 GLEBE ROAD Completed by Funeral 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5 -0-HOMEMAKER OWN HOME other Department of Health and Mental Hyg Important: If Item 27 is marked other eny injury or other traumatic event, sonce. Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) JOHN FRANKLIN SEWARD FLORENCE CLEVENGER Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD CHANCE, JR./ SON 414 GLEBE ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEMETERY 1-23-2006 CENTREVILLE, MD 21. Signa Profo Funeral Service Lie 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Cause (Fig. 1) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3CC/121/20 **Physician** SUBELION MESENTELIC OLLAN /Medical Due to (or as a consequence of): Examiner Hypokalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (er as a consequence of): Examine 2, world Nemag 1schemia attending physician and for use as the burial-trandeath certificate be execu Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? brovascular Deller T 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 8 1 Yes 2 X No al or Attending Physician: safter death.
I Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) thin 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1-19.06 D63726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MAJEKODUNMI, 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Green & Spark JAN 2 0 2008 DHMH 17 Rev 1/2001

			1 - For State Registrar		Maryland / Dep	partment of ertificate of		nd Mental I	Hygiene Reg. No.	06 0	3713
	Physici	an	Decedent's Name (First, Middle	le, Last)				2. Date of Month	Death Day	Yeer	3. Time of Death
	/Media		SARAH ELIZABET			Tru		IAR		5-2026	283 AM
	Examir	er	4a. Fecility Name (If not institution	n, give street and numb	θr)	4b. City, Town	or Location of	Death	40.0	county of Death	0
			5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda)	If Under 1 Yea	r If Under 2		Birth	9. Birtho	Van Def lace (State or Foreign
	Funeral Director		218-54-3521	1 □ M 2 X) F	63 Yrs.	Months Day		Min. (Month	Day, Year)	942 MD	itry)
			Usuef Residence of Decedent					, , , , , , , , , , , , , , , , , , , ,			
	arylan show		10a. State 10b. County		10c. City, Town or I	Location				1	0d. Inside City Limits
	8a-f	Director		ARUNDEL	GLEN BUF						1 Tes 2 No
	vith th	D.	10e. Street and Number			10f. Zip Code				of What Coun	itry?
	s 23s	eral	7575 E. HOWARD	ROAD	at Ever in U.S. 12	21060		a? (Specify Vac o	USA	1. Race - Americ	an Indian
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Alsal Evaninat must be rotified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Wildowed 4 Divorced	ned 1 ☐ Yes 2	es? X No	I. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 N	ıban, Mexican,	Puerto Rican, etc.)	Black, White,	etc.
21215-0036	thon stura	Completed by	41	nt's Education	16a. Dec	edent's Usual Occ	upation		16b. Kind	d of Business/Inc	dustry
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<u>Na</u>	should be ind Mental markad o umatic eve	2	(UNKNOWN)				(UNKN	IOWN)			
Maryland	and and is mu		19a. Informant's Name/Relations			iling Address (Stre				Town, State, Zip	Code)
	1 and Health tem 27		CALVIN E. CALL	IS/SON		MARSHY H	OPE RD.		-	19943	
9	e = 5		20a. Method of Disposition 1 ☐ Buriaf 2 X Cremation	3 □Removal from St	20b. Place of Dis cemetery, cr	ematory or other p	TION	Date		ation - City or To	wn, State
Ë			`4 □Donation 5 □ Other (S		4	KE CREMA LLC.		1/16/2006	STE	VENSVILI	E, MD
Baltimore,	permit. Par Departmen Important: any injury.		21. Sig re of F eray Service	AR		NNAPOLIS	ERAL &	CREMATIO		, 814 BE	STGATE RD.
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complicit that cau t only one cause on each	ised the death. Do not e			ardiac or respirato			Approximate Interval Between Onset and Death
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O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ 1 → 2 □ No 9 ☑ Unknown		h 2 ☐ Fetal death 3 nt at time of death 5	B Ectopic pregnar			23	Bd. Date of delive	ory Day Year
s, P	es De	b	Part II. Other significent conditions of the second			, .	given in Part I.		Did tobacco us		ne cause of death?
Ö	w requir been si should	ete	0, 600	, ,	port just			040.1	Was an	Odb. Mars auto	nou findings available
of Vital Record		Completed						8	utopsy performed?	prior to condeath?	psy findings available npletion of cause of
Z.	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			Thor	of Death (Check o			
	ng Phys fter this neral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date of		of 28c. in	4 [] (4u)	sing Home 5 🗆 I 28d. Descr	ribe how injury		Y)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:		not be 28e Place o	f Injury - At home, farm,		∏Yes 2 □N 	28f. Locati	on (Street and r Town, State)	Number or Rura	Il Route Number,
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	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physician: To the b I Examiner: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred at the investigation, in m	time, date and y opinion, death	place, and due to n occurred at the ti	the cause(s) a me, date and p	ind manner as si place, and due to	tated. the cause(s)
	To th To th compl	Me	29b. Signature and title of certific	1. 1			ense number			signed (Month,	
)			Varies	ula.	eren !	1	-46	761	Three	open /	3 5 2036
			30. Name and address of person	who completed cause	of death (Item 23a) (Typ	e, Print) DA	Ruis	a. Co	utron)	
			30. Name and address of person	TWO DRIC	e The	n Bra	neve,	cus ?	1140	•	
	Sta Regist	ate rar	31. Date filed (Month, Day, Tear	0 2006	gistrar's Signature	beiles					

Patrio 06-07 AKG	ck M. C 58	os	tello Please Amend item#1, Unpe	Type or Print nd item#23a,2 State of Mar	in Blac 7,28a f ryland /	k Ind pend Depa	lelible ink 1,833,3/1 rtment of F	3/65 TT A lealth and i	II Copies	s Are	e Legible.	00711
AKG			1 - State Registrar				rificate of			Reg. N	ZUUh	03/14
	Physici		1. Decedent's Name (First, Middle, Las	Patrick l		ello			2. Date of D. Month Janua		30, 2ŏ86	3. Time of Death 1:16 P M
8	/Medic Examin		4a. Facility Name (If not institution, give 267 Sycamore Road		, 34.		4b. City, Town, o Elktor	r Location of Death			4c. County of Death Cecil	1.10 1
709	Funeral Director		5. Social Security Number 6. Security Number 118-62-8944	7. Age ((In yrs. last bi	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D April	irth ay, Yea	9. Birthp Coun	ace (State or Foreign try) NY
	with the Maryland to or 28a-f show	,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov		ation				11	0d. Inside City Limits 1 ☐ Yes 3€ No
	28a-f	Director	MD Cecil 10e. Street and Number		Elk	ton	10f. Zip Code			10g. (Citizen of What Coun	
	th with		267 Sycamore F	Rd.			2192	1			S.A.	,
	r deeth	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S.	13. W	as Decedent of H	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race - America Black, White, 6	
9600	hours atter ural, or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📆 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1	□Yes 2XINo	Specify:			Specify:	White
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylar Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+))	a. Decede (Give k life. Di		pation during most of world)	king		Kind of Business/Ind	
DC 2	e filed at Hygi other vent,	Be C	17. Father's Name (First, Middle, Last)		1 11	Ove		18. Mother's Nam	ne (First, Middle			MOVING
ylar	Menta Menta arked	ToE	Arron Bonho	rst				Theres	a Long	ne	cker	
Mar	12 sho h and 7 is m reum	. 1	19a. Informant's Name/Relationship (T								or Town, State, Zip	Code)
-	Heelt Heelt tem 2		Christine Jenki 20a. Method of Disposition	ns/Fiance	20b. Place of	67_S of Dispos	Sycamor tion (Name of atory or other place		Date		MD 21921 Location - City or To	wn, State
ē	Pages ent of nt: If I		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removal from State	R.A.		atory or other plac cris In		uary 006			
Baltimore,	permit. Departmimporta any inju		21. Signature of Fufferat Service Licens	500			Name and Addre	ss of Facility			st Chest	er, Pa
	20 E # 9		23a. Parti. Shter the disease, or comp shock, or heart failure. List only of			A1 25	orew G	. Gee F ain St.	. Elkt	on:	ome , MD 21	921 Approximate
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Mixed Drug Due to (or as a	intoxic	ation						Approximate Interval Between Onset and Death
60,	eath centificate be executed attending physicien end for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a o								
9289	ficate physis the	edica		d								
P.O. Box	The law requires thet the death certificate be site has been signed by the attending physicit page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)	,			23d. Date of deliver Month	ry Day Year
	tuires thet n signed b	þ	Part II. Other significant conditions co	entributing to death but	not resulting	in the und	derlying cause giv	en in Part I.			use contribute to the	e cause of death?
OS E	aw requir Is been si 2 should t	piete							24a. Was		24b. Were autop	sy findings available
Ä	sicien: The law certificate has b irector, page 2 s	Completed							auto perf	ormed?	death?	npletion of cause of
/ita	Physicien: r this certific ral director.	Be (25. Was case referred to medical examiner?					26. Place of Dea				
of	Physic rthis ral dir	5	1 Yes 2 No 27. Manner of Death		2 ER/O	utpatient Time of		4 🗆 Nursing H	ome 5 ☐ Res 28d. Describe		Other (Specify	at scene
ion	Attending in death. Cotor: Alter by the fune	ation	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day) Fnd 1/30/200		1:00	28c. Injun World DM 1 □		nk	11011 111	lary occurred	
Division of Vital Records,	를 를 들	Certification;	3 ☐ Suicide 6 M Could not be determined	28e. Place of Injury building, etc. Found at re	y - At home, fa (Specify)	arm, stree			28f. Location (City or To	wn, Sta	and Number or Rural ate) 267 Sycam	Route Number, ore Rd.
	To the Hospitel within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier (Crisck only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of	xamination ar	e, death i	occurred at the tin	ne, date and place, pinion, death occui	and due to the	cause	(s) and manner as stand due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and manner state	nu.		29c. Licens	e number			Date signed (Month, C	**
			30. Name and address of person who c	ompleted gause of dea	th (Item 23a)	(Type, P		. 				
			ZABIUCCA+	AGG	111		-	, Baltimo	ore, Ma	ry1a	and 21201	
	Sta Registr		FEB 0 9 2006	32. Registrar	s Signature	Soci	San B					

		1 - State Registrar 1. Decedent's Name (First, Middle,	Last)	Cer	tificate of	Death	2. Date of De.	Reg. No. UU	3. Time of Death
Physici /Medi		JAMES H.	CRONIC, SR.				Month	Day 200	Year 15 35 M
Examir	ier	4a. Facility Name (If not institution, Pen/1/54/A Regional		11		or Location of Death		4c. County of	comico
ineral ector		5. Social Security Number 256-42-2473 Usual Residence of Decedent	5. Sex 7. Age (In yrs	77 Yrs.	If Under 1 Year Months Days		8. Date of Bin (Month, Da DEC . 2	th y. Year) 8, 1928	9. Birthplace (State or Foreigr Country) ALABAMA
rottiled at	ctor	DE 10b. County SUSSE		AUREL	cation				10d. Inside City Limits 1 ☐ Yes 2 📆 No
3s or 28	i Dire	10e. Street and Number 29168 E. TRAP F	OND RD.		10f. Zip Code 199	56		10g. Citizen of Wr USA	nat Country?
CONTRACT MEDICAL	by Funeral Director	11. Marital Status 1 Never Married Married Married Divorced	12. Was Decedent Ever in I Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 195/		Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto o Specify:	ecify Yes or No Rican, etc.)		- American Indian, White, etc.
	Completed	15. Decedent's (Specify only highest	Education	16a. Deced	ent's Usual Occu	during most of work	ing	16b. Kind of Bus	
	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		CITY GUA			COUNTY A	DMINISTRATION
	To Be C	17. Father's Name (First, Middle, L. JAMES A. CRONI	C				e (First, Middle, ALLEN	Maiden Sumame,)
		19a. Informant's Name/Relationshi OFELIA CRONIC	р (Турө, Print) — WIFE		,	et and Number or Run PPONDRD.			
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	Removal from State	Place of Dispos cemetery, crem	sition (Name of atory or other pla	ace)	Date	20c. Location - C	ity or Town, State
NILL OF		4 ☐ Donation 5 ☐ Other (Special Service Li			IEM. CEM Name and Addr	ress of Facility	-		ORO, DE
		Leonem	Stort	60	9 E. MA	KKET ST.,	GEORGET	UNERAL S OWN, DE	19947
		23a. Part1. Enter re disease, or c shock, or heart failure. List or Immediate Cause (Final	nry one cause on each line.				or respiratory ar	rrest,	Approximate Interval Between Onset and Death
i		disease or condition resulting in death)	Due to (or as a conse	quence of):		•			12 HRS
	Je.	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CEREBI Due to (or as a conse		HUPO	MA			2 Dous
	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE Due to (or as a conse		01N6	APRIC	DISSE	CTZON	Zpons
	<u>a</u>	•	d HUPER	15N	5000				YCARS
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnand Other (specify)	су		23d. Date Monti	
	2	Part II. Other significant condition	s contributing to death but not re	sulting in the un	derlying cause g	iven in Part I.			oute to the cause of death?
	Completed						24a. Was autop perto 1 \(\text{Yes} \)	psy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deatl	(Check only o	nne)	
	n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3□ DOA 28c. Inju	ther: 4 Nursing Ho		dence 6 Other	
	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	of be an of the second	nome, farm, stre	M 1	Yes 2 No	28f. Location (S City or Tow	Street and Number	or Rural Route Number,
					consumed at the t				
III to III po	I Cert	29a Certifier 1 Certifying	Physician: To the best of my kn kaminer: On the basis of examin	ation and/or inv	estigation, in my	opinion, death occurr	ed at the time,	date and place, an	d due to the cause(s)
	edical Cert	29a. Certifier 1 Certifying (Check only one) 1 Medical E	and manner stated.					29d Date signed /	
completely filled in by the	Medical Cert	(Check only 2 Medical Ex	and manner stated.	el w	29c. Licen	se number			(Month, Day, Year) 2006
To the Funstal Director: A completely filled in by the fu	Medical Cert	(Check only 2 Medical En	and manner stated.	el m (D-Print)	22132		Fel 1	,2006.

ORIGINAL

			1 - Samend Item#1 po	State of March PHY G85	arylar 3 3/	nd / Depa 1/606 e	artmer <i>Rificat</i>	t of H	ealth a Death	and M	ental Hy	giene Reg. No	006	03	716
	Physici	an	1. Decedent's Name (First, Middle, La.	st)							2. Date of De Month	aath Da	, Y	3. Tim	ne of Death
	/Media			CILIA	DI	RUCKER					JANUAR		200 و		30P M
1	Examir	er	4a. Facility Name (If not institution, giv 3701 INTERNATIONA		016				Location o	of Death			County of		
a k red	Funeral	ji .	5. Social Security Number 6. S			last birthday)	SILVI If Unde	r 1 Year	If Under		8. Date of Bir	rth		OMERY Birthplace (Sta	ate or Foreign
	Director		119-32-2949	□ M 2 🔀 F	7	76 Yrs.	Months	Days	Hours	Min.	IARCH 3	y, Year) , 19		Country) LOMANIA	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Insid	de City Limits
	Marylan a-f show	tor	MARYLAND MONTGOM	ERY		S	ILVE	R SPR	ING					₩ <u></u>	Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Cit	izen of Wh	at Country?	
	e 23e	erai	3701 INTERNATIONA	L DRIVE #3		S 12	Man Dani		906	-:-2 /C	at. Van aakt			S.A.	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural" or iteme 23e or 28e-f show minioupdecasher traumatic event, i'm Medical Evant far minist be notified at once.	by Funeral	Narital Status Never Married 2 Married Widowed 4 Morried	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No No		was Dece If Yes, spe 1 ☐ Yes		Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	0-		White, etc.	
15-0036	n 72 hor	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Dece (Give life.	dent's Usu kind of wo	rk done d	uring mos	t of workir	ıg	16b. K	ind of Busin	ness/Industry	
2121	d withi	omb	Elementary/Secondary (0-12)	College (1-4or 5	5+)		SS DE	,					DRES	SES	
nd	al Hyg	Bec	17. Father's Name (First, Middle, Last)		•					r's Name	(First, Middle	, Maiden		D110	
yla	ould to	70	JULIUS FELD							NA KO					
Maryland	id 2 sh ith and ith and traum		19a. Informant's Name/Relationship (HEATHER D. FITTER	• •			-				OMAC ,		r Town, St. 20854	ate, Zip Code)	
Ē,	s 1 and 1 Heal		20a. Method of Disposition	-	20b. F	Place of Dispo cemetery, crer	sition (Na	ne of			ate			ty or Town, State	е
imo	Page nent o		1 ☐ Burial 2XI Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		,	ROPOLI	-)1/24	/2006	FAL	LS CH	URCH, V	IRGINIA
Baltimore,	permit. Departr Import. eny inj		21. Signature of Funeral Service Licer	Otottle	ny	DA 11	Name ar NZANS 70 RC	Addres	s of Facilit OLDBI LLE I	ERG M	EMORIA ROCKV	L CH ILLE	APELS	, INC.	20852
i			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			th. Do not ent	er the mod	le of dying	g, such as	cardiac or	r respiratory a	rrest,	,	Approxi	-
A de la constante de la consta	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as			CANC	ER_							YEARS
8	ed sit	liner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consec	puence of).									
o,	death certificate be executed e attending physicien and ind for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consec	quence of):								-	
68760,	licate be ex physicien s the burial	edicai		d.											
Вох	death certifica attending pt d for use as ti	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			JEctopic p	regnancy					23d. Date of	•	
o.	that the dea led by the at detached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□ Unknown			Other (sp						Month	Day	Year
ds, P.	90	þ	Part II. Other significant conditions of	ontributing to death b	ut not res	sulting in the u	nderlying o	ause give	n in Part I.			obacco (ute to the cause	
Record	> .0 0	Completed									24a. Was		24b. We	re autopsy findir	ngs available
_	The ate h page	Com									auto perfo	rmed?	dea	r to completion th? Yes 2 No	of cause of
Vital	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Hospital:				Otha		of Death	(Check only	опе)			45.23
of	Phys this ral dii	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 🗆 inpatie		ER/Outpatier 28b. Time of			4 🗆 Nu		ne 5 X Resi 8d. Describe			(Specify)	
ion	Attending in death.	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	28c. Injury Work 1 🔲 Y	? ′es 2 □ l	,			,		
Division	effe Diri	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At h c. <i>(Specil</i>	ome, farm, str fy)	eet, factor	y, office		2	8f. Location (City or To			or Rural Route I	Vumber,
	Nospital or Att	edical C	29a. Certifier 1 X Certifying Ph	ysician: To the best	f examina	owledge, death ation and/or in	h occurred vestigation	at the tim	e, date an	d place, a th occurre	nd due to the	cause(s)	and mann place, and	er as stated. I due to the cau	se(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and tyle of certifier	and manner sta	ateu.		296	c. License	number			29d. Da	e signed (/	Month, Day, Yea	ir)
	V		1 Chilely	aye				D42	452			JANU	ARY 2	3, 2006	
		H	30. Name and address of per DR. CHITRA RALAGO	PAL, 18111	eath (Iter PRI	n 23a) (Type, NCE PH	Print) ILIP	DRIV	E #32	2, 0	LNEY, 1	4ARY1	LAND	20832	
*	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 20	33 Registr	ar's Signa	ature /	uli)		-						

2000			1 - For State Registrar		aryland		artment of H		nd Mental H	Reg. No	UUD	03717
L.	Physici	an	Decedent's Name (First, Middle, Last	•					2. Date of E Month	Da		3. Time of Death
	/Medio	al	Bessie F. Dick 4a. Facility Name (If not institution, give				4b. City, Town, or	r Logation of	Janua	_	8, 2006 County of Dea	1:30 P.M
	Examin	er	Sunrise Assisted				Severna		Dealli		nne Aru	
	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E			rthplace (State or Foreign country)
	Director		578-48-2062 Usual Residence of Decedent	M 2OF	9:	3 Yrs.	Months Days	Hours	Oct.	3, 1		shington, D.C
	how	_	10a. State 10b. County			, Town or Lo						10d. Inside City Limits
	8a-f	Director	Maryland Anne Ar	undel	Edg	ewater						1√2 Yes 2 No
	with th	D I	10e. Street and Number 425 Maple Leaf Dr:	ive			10f. Zip Code 2103	7			itizen of What C	ountry?
	heath ne 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	6. 13.		-	n? (Specify Yes or N	1	14. Race - Am	erican Indian.
39	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or iteme 23s or 28s-f show raumatic event, its Medical Exercipations.	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	10		f Yes, specify Cuba 1 ☐ Yes 2 <mark>X</mark> No	Specify:	n? (Specify Yes or I Puerto Rican, etc.)		Black, Whi	ite, etc. White
21215-0036	2 hou	Completed	15. Decedent's Edu (Specify only highest grad	ucation			dent's Usual Occup		of working	16b. H	Cind of Business	Jindustry
2	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work done of DO NOT use retired	dunng most (d)	or working			
	led w lygien her th	Co	12 Years			Home	maker		A. (m) - A.()		Own Home	9
and	d be fi	Be	17. Father's Name (First, Middle, Last) Mayer Furr						s Name (First, Midd		n Sumame)	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic events.	To	19a. Informant's Name/Relationship (T	vpe. Print)		19b. Mailir	ng Address (Street		chel Wofs		or Town State	Zin Code)
S	nd 2 state are trau		Thomas M. Dicken						e, Edgewa			
Baltimore,	S 1 and Head of Head		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	201	Date	20c. L	ocation - City o	Town, State
Ē	Page in the sage		1 ☐Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		1 .		m. Garden	1	20/2006	011	ney, Mai	ryland
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	iee O		22 F.d	. Name and Addre		eral Dire			,
_	70 E # 9		Ocnold (:	Lotte	my	2 10	91 Rocky	111 ₂ P	ike Rock	vi114		land 20852
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ine cause on each lin	10//	. Do not ent	er the mode of dyin	g, such as ca	ardiac or respiratory	arrest,	,	Approximate Interval Between Onset and Death
Ш	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		F						4/9
п	Examiner			Due to (or as	a consequ	ence of):						رينك
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	rate be executed thysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.								
Ö,	e exe ien ar urial-t		resulting in death) Last	Due to (or as	a consequ	ence of):						
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9 ×	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome	of oregonar	acv.						
Вох	leath certif attending I for use as	cian	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 🗍 Fetal	death 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	Day Year
<u>о</u> .	at the de by the tached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown								
	res that igned b be deta	by Pi	Part II. Dther significant conditions co	ntributing to death b	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	d tobacco	use contribute t	to the cause of death?
ord	w require been si should l								1,5	Yes 2	2 🗆 No 3 🗇 P	robably 4 🗀 Unknown
Vital Records,	has has	Completed	n		-				pe	is an copsy formed?	prior to death?	
ita	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?					26. Place o	of Death (Check only		0 12.10	
×	hysic his ce	70	1 ☐ Yes 2 ☑ No	Hospital: 1 🗌 Inpatie		ER/Outpatier	t 3 DOA Oth	er: 4 Nurs	sing Home 5 🗆 Re	sidence	6 ☐Other (Sp	ecify)
Ĕ	ding Phy h. After thi funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describ			
isio	Attender death	icat	2 Accident investigation 3 Suicide 6 Could not be	Otto Diago of Ini	.a. At box			Yes 2 □N		/Ct		Dural Carlot At The
Division of	after after Direct	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	me, rarm, str	eet, factory, office			own, Stat		Rural Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	edicai C	29a Certifier 1 Dertifying Phy (Check only one) 2 Medical Exam	reinian: To the best of iner: On the basis of	examinati	vledge deatt ion and/or in	occurred at the tir	ne, data and pinion, death	place, and dee to the occurred at the time	a caues(e e, date an	e) and manner and place, and du	e to the cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner sta	1100.							
			Dan Vill	110 111	1		03.	5718		81	1-19-20	06
	18		30. Name and address of erson who co	ompleted cause of d	eath (Item	23a) (Type,	Print)	150	4 mags!	CS	402	1401
	Sta	te	31. Date filed (Month, Day, Year) JAN 2 6 200	2. Registr	ar's Signati	ure /	M. D	- (yes.	1	- 60	
×	Regist		JAN 26 200	6 Denne	15	P. Dille	260					

			1 - For State Registrar			Depar	tmen	t of Health and Me of Death	lental Hy	giene	egible.	03718
			Decedent's Name (First, Middle, La.	st)			mean	C OI DCUIII	2. Date of De	Reg. No.	-	3. Time of Death
	Physici		Marshall Absolem	Durboraw	7				Januar	v 25.	2006	10:30 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number			4b. City,	Town, or Location of Death		1	ounty of Death	
			16646 Shinham Ro	ad			Hag	gerstown		Was	hingto	1 County
	Funeral		5. Social Security Number 6. S		ge (In yrs. last b	7/	If Under Months		8. Date of Birt (Month, Da	h v, Year)		place (State or Foreign
	Director		213–18–9206 Usual Residence of Decedent	A.W. Z. I	34	Yrs.			Jan.4,	1922		yĺand
	land ow		10a. State 10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Limits
	Many a-1 sh	tor	Maryland Washir	ngton		H	lagei	cstown				1 ☐ Yes 🏋 ☐ No
	th the or 28,	irec	10e. Street and Number		-		10f. Zip	Code		10g. Citize	n of What Cou	ntry?
	23a ust b	Funeral Director	16646 Shinham Ro	ad				21740		U.S	.A.	
	ar dez	nue	11. Marital Status	12. Was Deceden Armed Forces	?	13. Wa	as Decec Yes, spec	lent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	. Race - Ameri Black, White	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes X☐ If Yes, Give Year or Dates:			☐ Yes					Mhite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show he Medical Examiner must be notitied at		15. Decedent's Ec			a. Deceder	nt's Usua	Il Occupation	- International Control of Contro	16h Kind	of Business/Ir	dustry
215	hin 72 an "na	piet	(Specify only highest gra	de completed) College (1-4or		(Give kii	nd of wor	rk done during most of worki se retired)	ng .	TOD, TUITO	01 2431103411	addity.
21	filed with Hygiene. othar thar	Completed	6	oonego (1 401	34,	I	oad	Operator		Pav	ing Con	ipany
nd	be filed ital Hygi id othar avant, I	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle,	Maiden Su	ımame)	
₹	2 should be and Mental is marked o	L 0	Jacob Durboraw						ervia R			
Maryland	12 sh h and 7 is m traum	0 1	19a. Informant's Name/Relationship (19	b. Mailing	Address	(Street and Number or Rura	l Route Numbe	er, City or T	own, State, Zij	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28a-f show any injury or other traumatic avant, the Madical Examiner must be notified at once.		Nathan Durboraw 20a. Method of Disposition	(son)	20b. Place	1365 of Disposit	6 Gr	reencastle Pil	te Hager	rstow	n Maryl	and 21740
ğ	ages ant of t: If It		1X Burial 2 ☐ Cremation 3 ☐									
Baltimore,	permit. Pages Department of H Important: If Its any injury or of		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 	·	Cedar							Maryland eral Home
ã	Depa Impo any i		De October	0.		19072		astern Blvd.			_	
		7	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication that cause	ed the death. Do	not enter	the mode	e of dying, such as cardiac o	r respiratory ar	rest,	WII MALY	Approximate
E	Physician		Immediate Cause (Final disease or condition	a Renal								Interval Between Onset and Death
	/Medical		resulting in death)		s a consequence	e of):						Une month
В	Examiner		Sequentially list conditions.	b. Carunai		Dist	475					Years
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Unionship Cause (Disease or injury that initiated events	Due to (or as	s *consequence	of):					1	NI.
	and all-tran	хап	that initiated events resulting in death) Last	c. Dinhere	& Mellitys	Type	2					Years
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89				0	100 - 4 - 4 - 4	001001	W DEBL					
Вох	h cert andin use	M/ul	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal deat					230	d. Date of deliv	ery
O.	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		ctopic pro Other (sp				Month	Day Year
<u>م</u>	at the	Physician/Med	9 Unknown									
Ś	Attanding Physician: The law requires that the death certifica r death. r death. actor: Atter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions c	ontributing to death i	but not resulting	in the unde	erlying ca	ause given in Part I.				he cause of death?
Ö	w requir been si should	eted										pably 4 QUnknown
Record	: The law cate has b	Completed							24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical						1 ☐ Yes	2 ☑ No	1 🗆 Yes	2 No
\equiv	s certi	o Be	examiner?	Hospital:	ient 2 ER/O	Autastiont	3 DO	26. Place of Death Other: 4 Nursing Hor			70th (0	
Division of Vital	g Phy er this	F .	27. Manner of Death	28a. Date of Inj	ury 28b.	Time of			28d. Describe h			у)
Ö	andin lath. or: Aft	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay rear)	Injury	М	Wark? 1 ☐ Yes 2 ☐ No				
<u> </u>	or Attanding Physician: after death. Diractor: Atter this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	ijury - At home, f	farm, stree	t, factory	, office	28f. Location (S City or Tow		lumber or Rura	al Route Number,
	urs aff											
	To the Hospital or Attanwithin 24 hours after deation to the Funaral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	intier: On the basis (of examination a	ge, death o ind/or inves	occurred a stigation,	at the time, date and place, a in my opinion, death occurre	and due to the o	ause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
	To tha within 2 To the complet	Mec	29b. Signature and title of certifier	and manner s	tated.			License number			igned (Month,	
	⊢ <i>5</i> ⊢ ŏ		Bu and	, 100 m				10062647		1/27/		
			30. Name and address of person who	completed cause of	death (Item 23a)) (Type. Pri		-00204)		1211	v (b)	
51	4-5		A. A		10 21740		,					
	Sta		31. Date filed (Month, Day, Year)		rar's Signature	7	-					
	Registr	ar	JAN 30 20	106 4	R	Roce	J.					

DHMH 17 Rev 1/2001

ORIGINAL

			- For Amend #31 p		rylando Peni	artment	of Health	n and Me		J	03719
			Registrar		Ce	rtificate	of Dear	th	R	eg. No.	00,
	Physici		 Decedent's Name (First, Middle, Last) Charles Marshall 						2. Date of Dea anuary	th Day Year 23 2006	3. Time of Death 10:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, To	own, or Location	on of Death		4c. County of Dea	
			Frederick Memori				erick			Frederic	
l)	Funeral		5. Social Security Number 6. Sex 15. 337–16–6669	k 7.Age KM 2□F	(In yrs. last birthday) Q2 Yrs.	If Under 1 Months	Year If Und Days Hour	rs Min.	3. Date of Birth (Month, Day)	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		82 Yrs.				Nov. 11	, 1923 I11	inois
	ylanc		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Ba-f	ctor	Maryland Frederic	k	Frederic	k					1 ☐Yes 2 ☐ No
	filed within 72 hours after death with the Maryland Hygiene. sther than "naturel", or iteme 23a or 28a-f ehow sht, the Medical Exaritrat must be notified at	Funeral Director	10e. Street and Number			10f. Zip C			1	0g. Citizen of What Co	ountry?
	• 23e	erai	7407 Willow Road	10 Mac Deceded 5		W - 5 - 1	21702	0-1-1-2-10	7 7	U.S.A.	
	iten de	Į.	11. Marital Slatus 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? X☐ Yes 2 ☐ N		Was Deceder	ni of Hispanic y Cuban, Mexi	Origin? (Specican, Puerto R	ity Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
036	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2[XNo Spec	rify:		Specify: W	hite
2-0	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual	Occupation	nost of working	2	16b. Kind of Business	
2	han han	du	Elementary/Secondary (0-12)	College (1-4or 5-					1	D	D (
72	lled v Hygie ther ti		17. Father's Name (First, Middle, Last)	-		Bio-Ch		athere Name	Eirot Middle	Dept. of	Delense
Baltimore, Maryland 21215-0036	d is b	To Be	John Dahlgren					uise Ur		vialuen Surname)	
ary	should and Men amarke umatic	-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (Street and Nur	mber or Rural	Route Number	r, City or Town, State, .	Zip Code)
Σ	and 2 alth a 27 is		James Dahlgren / S	Son	6619	Christ	y Acre	Circle	e, Mt.	Airy, MD 2	1771
ore	of He of He of Item		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐R	lamoval from State	20b. Place of Dispo cemetery, crei	sition (Name matory or oth	of er place)	Da	te	20c. Location - City or	Town, State
Ē	Pages iment of tant: if it jury or o		4 ☐ Donation 5 ☐ Other (Specify)		Smithsbu	rg Cre	matory	1/25/	06 5	mithsburg,	Maryland
Ball	permit. Pages Depertment of I Important: if Its eny injury or o once.		21. Signature of Fun yral Service Lizery	Le Con	Rổ!	BERT E	Address of Fa	EY & SC	N, FUNE	RAL HOMES,	P.A.
	40200	-	23a Part 1 Enter the disease or compli	ications that raised	// 121	Ol NOR	TH MARI	KET ST.	FRED	ERICK MD	21701 Approximate
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line						est,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in dealh)	Dua to (or as a	consequence of):	rula	de	ude	N		8 days
	Examiner			000 10 (01 23 2	consequence or.						
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (Sr as a	consequence Jt).					1)	
	acuted and transi	Examiner	that initiated events								
760,	ate be executed hysicien and he burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
687	physic	dicai	d	1							
×	certifi nding use as	/Me	IF FEMALE:	3c. If yes, outcome of	of pregnancy					23d. Date of de	iven
Вох	death e etter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Petal death 3	Ectopic preg Other (spec				Month Month	Day Year
<u>о</u> .	t the c by the	hysi	9 Unknown	9□ Unknown							
	Attending Physicien: The law requires that the death certificat creath. •ctor. After this certificate has been signed by the ettending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cau	se given in Pa	ırt I.	23e. Did tol	bacco use contribute to	the cause of death?
ğ	equir	ted	Urry Vier	Affe	elia			<u> </u>	1 🗆 Ye	es 2. 2. 11√10 3 □ Pi	robably 4 Unknown
Records,	lawr las be	Completed	Chamin Celus	filial	lolya				24a. Was a autops	y prior to	utopsy findings available completion of cause of
<u>س</u>	cate h	Con	Prenow Con	elmes	weller (el	ride	5		perform	med? death?	2 □ No
Vital	icien certifi ector	Be	25. Was case referred to medical examiner?	lospital:			Othor		Check only on		
ō	Phys r this ral dir	. To	1 ☐ Yes 2 ☑ No '' 27. Manner of Death	1 Inpalier						ence 6 Other (Spe	city)
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Division of	Atter ector by the	Certification:	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm, str	eet, factory, o	office	28	of Location (St	reet and Number or R	ural Route Number,
٥	tal or rs afte ai Dir ed in	Cert	4 7 7 10 11 10 10 10 10 10 10 10 10 10 10 10	building, etc.	. (Ѕрвспу)				City or Town	n, State)	
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	icai	(Crieck only 2 Medical Examir	ner: On the basis of a	examination and/or in	occurred at vestigation, in	the time, date	and place, an	d due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.		License numbe			9d. Date signed (Mont	
	£.3 ₹.8		D .	1	1 In	0	1202	15/	-	1/20/2	006
• د ي	AV.		30. Name and address of person who co	impleted cause of de	ath (Item 23a) (Type	Print)	207	16		110110	6
+	04/4.		Formin E.	Perlee	MP 300	1 We.	9711	7. 1	relan	1. Mt	21701
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	4	IAND	M 2000	la.	Le d	· •
	Registr	ar	JAN 2 6 2	000	w B	Soul!	JAN 2	7 ZUUD	pole	U B A	ale

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Section Part					st)			2. Date of Death		3. Time of Death
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Played and Played	-	5 € 7 ±		Chony Love	(Daughter)	2404 S. W	Day Drive	Newark	DE 1	9713
Pitysician Medical Examiner Provincian Medic	ore	of He			20b. Pl.	ace of Disposition (Name emptery, cremptory or other	e of her place)	Date 20c.	Location - City or T	own, State
Pitysician Medical Examiner Provincian Medic	Ĕ	Peg nent ant: fi			Hemoval from State	Gracelawn	ark oal	01 2000 NO	ew Costl	e NE
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Physician Medical Examiner Part				23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused the death	. Do not enter the mode	of dying, such as cardia	or respiratory arrest,		Approximate
Due to (or as a consequence of): Seventially is; conditions, if any, leading to mimedial contributions of the contribution	ŧ.	Physician		Immediate Cause (Final		RANN DUCE	INICTION S	MARAME		Onset and Death
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The state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown	80	ath c	lan/		1 Live birth 2 ☐ Fetal	death 3 □Ectopic pre				•
25. Was case referred to medical examiner? 1		the e	/sic	1 ☐ Yes 2 ☐ No		ath 5 Cher (spe	ecify)		WORK	Day Toal
25. Was case referred to medical examiner? 1	<u>o</u> .	hat the d by detac	F	7.7	entributing to death but not recu	Iting in the underhing on	use given in Port I	23a Did tobacco	a uso contributo to	the serves of death?
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNS KIM 600 NOWTH WOLFE STREET BACTMONE MD 21287-9106	E		S							2D No
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNS KIM 600 NOWTH WOLFE STREET BACTMONE MD 21287-9106	Zi Zi	Iclan Sertifi Sector	00		Hospital:			th Check only one		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNS KIM 600 NOWTH WOLFE STREET BACTMONE MD 21287-9106	ot	9 =					4 Li Nuising F			fy)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNG KIM 600 NOWTH WOLFE STREET BACTIMORE MD 21287-9106		24 ho	dica	Check only 2 Medical Exert	iner: On the basis of examinati	on and/or investigation,	in my opinion, death occu	rred at the time, date a	s) and manner as s nd place, and due !	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNG KIM 600 NOWTH WOLFE STREET BACTIMORE MD 21287-9106		o thi	Me	29b. Signature and title of certifier		29c.	License number	29d. D	ate signed (Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HYVNH KIM 600 NOWTH WOLFE STREET BALTIMONE MD 21287-9106		r s h ō		V VIII	~0		D'E < A			
5 DAVID HYUNG KIM 600 NORTH WOLFE STREET BALTIMONE MD 21287-9106							VEN-000	3 751	JUNILY Z	7 2006
State 31. Date filed (Month, Day Year) 32. Regist tr's Signature		5					K STINERE 13	BATIMONE	MD 21	287-9ING
Pagistrar				31. Date filed (Month, Day Year) 2	32. Register's Signatu	ure H A.	K.	1,011	, , , , , , , , , , , , , , , , , , , ,	- 1,00

State of Maryland / Department of Health and Mental Hygiene [1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Merry Lou Dustin January 27, 2006 6:01/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Months Director 216-40-7221 64 Maryland Usual Residence of Decedent permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, Ira Medical Examinar must be nutritied. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes X No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24800 Half Pone Point Road 20636 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Gulf Stottlemyer Irma Duane Sager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Dustin / Husband 24800 Half Pone Point Road Hollywood MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Jan 31, 2006 Leonardtown, MD 21. Signal or of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Unichael Neur P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe metabolic aavonn **Physician** /Medical Examiner berne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has birector, page 2 si autopsy 2/No 1 ☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 275 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 24 hours after death.

Puneral Director: A investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 30/06 D0060973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mehrdad Akhlaghi, M.D. St. Mary's Hospital P.O. Box 527 Leonardtown MD 20650 31. Date filed (Month, Day, Year)

JAN 3 1 2006 . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	Physici /Medic			Albert	D'Ambı				Ja ₁	ite of Death onth nuary	28. 20		3. Time of Death 9:05 p.m.
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036	d within 72 hours after death with the Maryland jiens. Then "naturel", or Items 23e or 28e-f show The Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates:	ĺ		ecedent of His specify Cuban es 2 No	panic Origi , Mexican, Specify:	in? (Specify Yi Puerto Rican,	etc.)		- America , White, e Whit	etc.
1215-0036	n 72	Completed	15. Decedent's Edu (Specify only highest grad.	cation e completed) College (1-4or 5+)		(Give kind o life. DO NO	Usual Occupat f work done du IT use retired)	uring most	of working		b. Kind of Bus		
Maryland 2	al Hyg	To Be Co	9 17. Father's Name (First, Middle, Last) Samuel Albert	: D'Ambrosi	la, Sr.		Salesma	18. Mother	's Name (First,	Middle, Mai	iden Sumame)	1 Products
	es 1 and 2 should be the standard that the standard less than 1 standard cotten to the transaction		19a. Informant's Name/Relationship (Ty Michael Mead /	rpe, Print)	19b.	-		nd Number	or Rural Rout	e Number, C	ity or Town, S	state, Zip	ŕ
altimore,	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 □ Burial 2 🗑 Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		20b. Place of the commetery Brinsfi	Disposition r, crematory	(Name of or other place)	Date	200	c. Location - C	City or Tov	
Ball	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service License Edward N. Brinsfie	ld, Ir.		22955	Holly	wood	Road, 1	ield F Leonar	uneral dtown,	Home	e, P.A. 20650-0279
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Lec Lec	The lar ate has page 2	Completed								a. Was an autopsy performed Yes 2	d? de	or to comeath?	osy findings available inpletion of cause of 2 PM
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient	2 ER/Outp	nationt 3	DOA Other		of Death <i>Ched</i> sing Home 5		e 6 □Other	(Saacihi	·)
Division of	To the Hospital or Attending Physimiting A burner at the Funeral Director: After this completely filled in by the funeral director.	Certification; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Y	28b. Tir		28c. Injury a Work?		28d. De		injury occurre		,
	pital or Att urs after d aral Direct illed in by	Certifi	4 Homicide determined	28e. Place of Injury building, etc. ((Specify)				Cit	y or Town, S	itate)		Route Number,
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Į,	N 2 - 3 - 5		30. Name and does of person wh	mpleted cause of doc	A4 ()	vne Print	DO	964	119		2-1-	- Ok	5
1 /	1,		James . Jarboe,/	M.D., 2403	5 Three		h Road	, Hol	lywood,	Mary:	land 20)636	
坡	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's		x do	ركليه						

			For State Registrar	State of M	laryland /	•	rtment of H		ind Mental		ene	106	03723
			1. Decedent's Name (First, Mid	Idle, Last)					2. Date			V	3. Time of Death
	Physici /Medio		Mary	Alice		gle			Janu		Day 24	2006	9:00 P M
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			Kline Hospice			tiat to 3	Mou If Under 1 Year	nt Ai		. C. Directo		ederic	
	Funeral Director		5. Social Security Number 217-28-5300	6. Sex 7. A	ge (In yrs. last 72	Yrs.	Months Days	Hours	Min. 8. Date (Mont	of Birth h, Day, 1 20	/e <i>ar)</i> 1023	Cou	place (State or Foreign intry)
			Usual Residence of Decedent						Ilay	27,	1733		
	arylar show	_	10a. State 10b. Coun		10c. City, To								10d. Inside City Limits 1 ☐ Yes 2 🖾 No
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	item item	Š	11. Marital Status 1 □ Never Married 2 □ M	Armed Forces	?	If.	Yes, specify Cuba	in, Mexican	gin? (Specify Yes , Puerto Rican, etc	5.)	14.	Black, White	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "netural", or items 23a or 28a-f show or other treumatic event, the Wickel Examine must be maillist at	by F	3 ⊠ Widowed 4 □ Divorc	If Yes Give		11	☐ Yes 2 🔀 No	Specify:			Sp	ecity:	White
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7	hould Me mark matic	ည	19a. Informant's Name/Relatio		1	9b. Mailing	Address (Street		or or Rural Route N		,		ip Code)
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ē,	permit. Pages 1 and: Department of Health Important: If Item 27 any injury or other tr 20029.		20a. Method of Disposition		20b. Place	of Disposi	ition (Name of atory or other place		Date	2		ion - City or T	
Baltimore,	Pages nent of lant: If Its ant: If Its		1 ⊠ Burial 2 □ Crematio `4 □ Donation 5 □ Other	n 3 □Removal from Stat (Specify)	8		formed C		January 2006		iddl	etown,	Maryland
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m	Depa Impo any ir			to		16:	21 Oposso	umtowi	n Pike I	rede	ericl	k, Mar	yland 21702
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Вох	eath certifica attending ph for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal de		Ectopic pregnancy	,			230	. Date of delivery	•
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Ö	Itel or ris aft rel Di												
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier Certifier (Check only one)	fying Physicien: To the bea cal Exeminer: On the basis and manner	of examination	dge, death and/or inve	occurred at the tire estigation, in my o	πe, date an pinion, dea	d place, and due t th occurred at the	o the car time, da	use(s) an te and pla	d manner as ace, and due	stated. to the cause(s)
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			1 0	Xun y	m		DY	P71	69		1/2	25/2	006
-	F		30. Name and address of pers	on who completed cause o	death (Item 23	a) (Type, F	Print)	~	nswar	- 1	-		. /
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	Sta		31. Date filed (Month, Day, Ye	7 HO, MD.	Strar's Signature	91h	Ave,	Bru	uswood	4	~~	21/	16

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	Physici	an	1. Decedent's Name (First, Middle, Las Adele B. Fildern	•						_	Date of Deal Month anuary	Day	2006	3. Time of Death 2:55 P • M	
A STATE OF THE PARTY OF THE PAR	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, To		ocation of l			4c. C	ounty of Deat ntgome	h	
	Funeral Director		5. Social Security Number 6. Security Number 218-54-5814	x 7. Ag □ M 2√2 F		as <i>t birthday)</i> 8 Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min. Ma	Date of Birth (Month, Day, By 1,	1 ⁷ 9707		nplace (State or Foreign intucky	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Menalth Hygiene. Important: If than 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 4982 Sentinel Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grave) Elementary/Secondary (0-12) 12 Years 17. Father's Name (First, Middle, Last) Sidney Griffin 19a. Informant's Name/Relationship (7) Gloria M. Klein —	12. Was Decedent Armed Forces? 1 □ Yes 2 □ 1 If Yes, Give X Year or Dates: ucation the completed) College (1-4or 5)	Beth Ever in U.S.	16a. Deced (Give life. I Hom	Nas Decede f Yes, specif l Yes 2 dent's Usual kind of work DO NOT use emaker	2081 int of Hispy Cuban. No Occupate indone due retired) C Street armael 1	panic Origin Mexican, I Specify: ion ring most of 18. Mother's Lil	s Name (F lian or Rural R	irst, Middle, I Lightf	U 16b. Kind Ow Maiden S Oot City or	n Home umame) Town, State, 2	nican Indian, a, etc. hite Industry Tip Code) 20816	
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		20a. Method of Disposition Disposition)	Ce	ace of Dispo emetery, crer g Davi	d Mem	er place, Gd1	ns 1	Date /22/2 erg M Pike,	006	Fa11	s Chur apels, Mary	ch, Virgini	7
8760,	Physician per security of the principle	dical Examiner	23a. Part 1. Enter the disease, or compands, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Advance Due to (or as b. Due to (or as Due to (or as d.	a consequ	mentia Jence of): Jence of):		of dying,	such as ca	ardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death	
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Division of Vital Records,	r Attending Physician: The ler death. ler death. Irector: After this certificate ha by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Inju (Month, Da	y Year)	ER/Outpatier 28b. Time o Injury me, farm, str	M 28	c. Injury : Work?	4 ☐ Nurs	sing Home 28d	l. Describe ho	ence 6 ow injury	occurred	onyHospice I	Pl
ã	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Cer	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who charles Harrison	ysician: To the best iner: On the basis o and manner st	of my know f examinat ated.	wledge, deati ion and/or in	vestigation, i	License	nion, death	18	due to the cat the time, d	ause(s) a ate and p gd. Date Janu	signed (Month	h, Day, Year)	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 26	32. 9 gistr	ar's Signat	ture	met !								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** 12:44 PM RICHARD LEE FOWLER JANUARY 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Il Under 1 Year | Il Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1**X**M 2□F Vrs 80 WV 579–24–3957 21, 1925 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count r than "naturel", or iteme 23s or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No MD TALBOT **EASTON** Direct 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 29602 KENT AVENUE 21601 USA 12. Was Decedent Ever in U.S. Amed Forces?
1 X Yes 2 □ No If Yes, Give Year or Dates: 1943–1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or ite importent: of item 27 is marked other than "naturel; or item any injury or other traumatic event, the Medical Evantras once. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT 12 BUDGET ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THELMER C. FOWLER AMELIA LORIAUX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MURIEL FOWLER/WIFE 29602 KENT AVENUE, EASTON, MD 21601 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION CENTER, LLC. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 01/04/2006 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature if Suneral Service Licensee 22. Name and Address of LLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 6 SHAMROCK ROAD, CHESTER, MD 21619 23a, Part1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause go ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) heumonio /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2****No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗆 Yes 24 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 In atient 1 ☐ Yes 25 No. 2 ER/Outpatient 3 DOA Certification: To After the 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred Haturai 5 Pending after death.

i Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by within 24 hours after of To the Funeral Directompletely filled in by 4 | Homicide Hospitei certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ih e 29d. Date/signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 06

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #31 per/fh 01-27-2006 CM Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** 23 22:54 pm 2006 HNTHON 0 /Medical 4a Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPITAL MONTGOMER II Under 24 Hrs. GROVE If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dale of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1XM 2□ F NONE Director Usual Residence of Decedent filad within 72 hours aftar daath with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director URMUNT MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21788 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2No Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NFAN Hygiana. 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be 1 Haalth and Mantal EXAMDRE VONDE COLLINS 19a. Informant's Name/Relatio ship (Type, Print) 19b. Mailing Addrass (Street and Number of Rural Route Number, City or Town, State, Zip Code) HILLSIDE HVENYE, of Haalth PATHER MARYLAND 373 MEXANDRE HURMONT 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pegas ò **Department** 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/25/06 Smithsburg, Maryland na and Address of Facility RT E. DAILEY & SON FUNERAL HOMES, P.A. EAST MAIN ST., 615 THURMONT, MD 21788 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause o not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) And i O Dulmonar Due to (or as a consequence of): Examiner Examiner physician and s the burial-transit 0 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence Physician/Medical re Due to (or as e conseque ettanding p ed by tha e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown baan signed t should be date δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s Aftar this cartificete has #LIVes 1 ☐ Yes 2 ☐ No 2 XNU To the Funeral Director: Attar this cardific complately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient ٩ 2 ER/Outpatient 3□ DOA Manner of Death Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 Tes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death cartificete be axecuted Division of Vital Records, P.O. Box 68760, or Attending efter death. within 24 hours e Hospital

To the

Maryland 21215-0036

Baltimore,

State Registrar

29a. Certifier

(Check only one)

HEATHER

29b. Signature and title of pertifier

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) r's Signature 32. Regis

CAHAN.

9901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER

Descritifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 2] Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

D61585

DRIVE, ROCKVILLE, MARYLAND HN 2 7 2006 Jan & Spell

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmen					giene Reg. No.	306	03727
	Physici	22	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Media		Frances	Weila	nd	Go1ds	boroug	gh			Januar		, 2006	
1	Examir		4a. Facility Name (If not institution,	give street and n	umber)		4b. City,	Town, or	Location of	of Death		4c.	County of Dea	
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П	Funeral			. Sex 1 ☐ M 2 🗗 F		yrs. last birthday Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		rthplace (State or Foreign country)
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	and w		10a. State 10b. County		100	c. City, Town or L	ocation							10d. Inside City Limits
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ā	Menta Menta	To B	Francis We:	iland					Ger	trud	e Valla	ndin	gham	
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Baltimore,	of Hear flem		20a. Method of Disposition		20	Ob. Place of Disp	osition (Nam	ne of			Date		cation - City or	
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9036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show then "natural" to multifud at the Mudical Extending the multifud at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates:	?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
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	i		30. Name and odress of person w	mo mpleted cause of	death (Item 23a) /T	voe. Print)	5443	2	13/2004	•
	4	1/1	Tohaw Mie			ode Roal	Westm	inster M	13/2006	7
3	Sta Registr		FEB 0 9 200	6 Assertion	rans Signature	The same	/	J	,	

			1 - For Stete Registrar	State of	f Marylan	•	artment of I		and Mei		iene 9. No. 0 0 6	03729
	Dharaisi		1. Decedent's Name (First, Middle, L.	ast)					2.	Date of Deat Month	_	3. Time of Death
	Physici /Medic		Joseph E. H	ardesty						January		- 14
	Examin		4a. Facility Name (If not institution, gi	ve street and num	nber)		4b. City, Town,	or Location of	of Death		4c. County of	Death
			Hebrew Home of		-	<u></u>		cville			Montgo	
	Funeral			Sex 12XM 2□F	7. Age (In yrs.		If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year) 9.	. Birthplace (State or Foreign Country)
	Director		578-10-3814 Usual Residence of Decedent		9	90 Yrs.				Jan. 4,	, 1916 Wa	ashington, DC
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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	28a	Je C	10e. Street and Number				10f. Zip Code			10	0g. Citizen of Wha	at Country?
	3a or	<u> </u>	14400 Homecrest	Road, #2	27		2090	06				ted States
	death ms 2	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori	gin? (Specifi	y Yes or No-	14. Race -	American Indian,
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anc	be fill be fill be of ot	Be	17. Father's Name (First, Middle, Las William E. Hare							len Gat		
ž	d Mer d Mer mark matic	ဥ	19a. Informant's Name/Relationship			10h Maili	Address (Care	1			. City or Town, Sta	7- 0- 4-)
Maryland 2121	d 2 sl th and 7 is r traur		Robert J. Caspar		al Rep							
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiana. Department of Health and Mental Hygiana. Department of Health and Mental Hygiana. The Madical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. F	lace of Dispo	osition (Name of	1	Date	9 7	20c. Location - Cit	
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₹	artme ortan injury		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 	•	1 6		ill Cemet		2006			Maryland
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	No.		shock, or heart failure. List only Immediate Cause (Final	y one cause on ea	ach line.	6	_					Interval Between Onset and Death
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/isi	Attendi death. ctor: A	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place	of Injury - At he	ome, farm, st	reet, factory, office		28f	. Location (Sti	reet and Number o	or Rural Route Number,
á	al or A safter I Direction by	Certification;	4 Homicide determine	buildir	ng, etc. (Specil	y)				City or Town	n, State)	
	Hospital 24 hours a Funeral I	edical C	(Check only 2 Medical Exa	hysicien: To the	best of my kno	wiedge, deat	h occurred at the t	ime, date an	d place, and	due to the ca	ause(s) and manne	er as stated. I due to the cause(s)
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one) 29b. Signature and title of certifier	and manr	ner stated.			se number			9d. Date signed (A	
			1 0 -	112-			17 == 2	, (-2		-	1	75 300 5
	4+1		30. Name and address of person who	o completed cause	e of death (Item	23a\ (Type	D S F				Junury	25,2006
			Gara 3. Will	Completed caus	(al) i ev	Entrese	Rud	Role	ر مال	707	6352	
	Sta	ite	31. Date filed (Month, Day, Year)	32, 🖻	egistrar's Signa	ture	Print) Rend	101-01	(
	Registi		JAN 26	2006	due ,	K A	ويتاجه					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ALTCE CLENDANIEL HOXTER JAN. 04 2006 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14041 HACKNEY COURT QUEEN ANNE **QUEEN ANNE** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗶 F Months Director 213-18-5566 MAR. 15, 1919 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event. The Madical Examinar must be notified at 1 ☐ Yes 2 No MD QUEEN ANNE **QUEEN ANNE** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14041 HACKNEY COURT 21657 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 -0-BOOKKEEPER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN O. CLENDANIEL LULU V. GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET ANN ANDERSON/DAUGHTER 14041 HACKNEY COURT, QUEEN ANNE, MD 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Importent: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) STEVENSVILLE CEMETERY 1-7-2006 STEVENSVILLE, MD 21. Signature of Funetal FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line? Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (gras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ped 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending f Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 / Homicide within 24 hours a 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type/Print) 21617 31. Date filed (Month, Day, Year) 32. Registras Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 0.00

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	ifer death with the Mar r items 23a or 28a-f s iner must be notified Finneral Director		11. Marital Status		12. Was Dece Armed For	dent Ever in U,	S. 13. V	1	f Hispenic Origin? (S uban, Mexican, Puert	pecify Yes or No-	14. Rac	e - Ameri ck, White,	can Indian,
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P			× Kat	WH	α	0/10	Y MI		2010	28	1/2	1//	26
		3	30. Name and address of	person who d	completed cause	of death (Item	23a) (Type, I	Print)					
_			RAKESH ARO					K LANE,	SUITE 222	, BOWIE,	MD 20	715	
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			For State Registrar		State of M	laryland	/ Depa		of H	ealth a		ntal Hy		006	0373	3
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	ter death items 2%	era	11. Marital Status	7711 111 120	12. Was Deceden	t Ever in U.S.					jin? (Speci	fy Yes or No		14. Race - Am		
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Maryland	s 1 and 2 should by I Health and Menta item 27 Is marked other treumetic ev	-	19a. Informant's Nan	ne/Relationship (T)	rpe, Print)	T.	19b. Mailir	ng Address ((Street a	nd Number	r or Rural F	Route Numb	er, City o	or Town, State,	Zip Code)	<u> </u>
	and 2		VINCENT	McCRACK	EN - SON		213	EDGE C	F TO	OWN DI	R., C	HESTER	RTOW	N, MD 2	1620	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe			osition Cremation 3XDF Dother (Specify)	Removal from State	cem	etery, crei	sition (Name matory or oth DWS CE	her place		Dat -10-6			ocation - City o		
alti	permit. DepartmImports Imports any inju		21. Signature of Fun	eral Service Licens	ee / /	1	22	. Name and	Address	s of Facility	BER	RY-SHO	ORT 1	FUNERAL	HOME	
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687	phys phys s the	edic			d	· IF		0000								
Box (death certifica e attending ph ed for use as th	n/M	IF FEMALE: 23b. Was decedent;	pregnant 2	3c. If yes, outcom			- 10						23d. Date of de	elivery	
Ď	the atte	Physician/M	in the past 12 m	nonths?	1 ☐ Live birth]Ectopic pre] Other (spe		<u> </u>			1	Month	Day Yea	ar
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	es ign be	þ	Part II. Other signific	ant conditions co		but not resultir	ng in the u	nderlying ca	use give	n in Part I.					to the cause of dea	
ord	w require	Completed	The p	, , , ,							_	- '-	Yes 2	□No 3□F		
3ec	has b	mpie										24a. Was		24b. Were a prior to death?	autopsy findings ava completion of caus	arlable se of
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o	g Phy er this eral d	-	27. Manner of Death		28a. Date of Inj	jury 28	b. Time of		c. Injury Work			d. Describe			өспу)	
Ö	Attending r death. sctor: After	atio	√ Natural 2 ☐ Accident	5 Pending investigation	(Month, D	ay rear)	Injury	М		es 2□N	No					
Division of Vital Records,	r Atte	ertification	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Ir building, e	njury - At home	a, farm, str	eet, factory,	office		28	f. Location (: City or To			Rural Route Number	r,
	Hospitel or 14 hours afte Funerel Dire tely filled in t	O	<u> </u>													
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only 2 one)	☐ Certifying Phy	sicien: To the bes ner: On the basis and manner s	of examination	dge, death and/or in	n occurred a vestigation, i	t the time in my op	e, date and inion, deatl	d place, and th occurred	d due to the Lat the time,	cause(s date and) and manner a d place, and du	as stated. ue to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and ti	tle of certifier	and mainers	itateu.		29c.	License	number			29d. Da	ite signed (Mor	nth, Day, Year)	
	⊢ \$ ⊢ ō		ALE	light O	naoula	is out			Do	003	37,			2/3/00		
	•		30. Name and address	ss of person who co	ompleted cause of	death (Item 25	a) (Type,	Print)	y 00	4 7	- 11			2/3/50 pous		
_	10		ANNE	ARMA DE	L MED	CYK,		MEDI	CH	c 1	PKuy	· 400	NA	pours		
***	Sta	_	31. Date filed (Month		4	trar's Signatur		1	rej.							
	Registr			EB 0 9 2	006	we d	8	oou!	,							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 25,29a per verbring 25,02/09/06dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Herbert B. Inghram 7=10 P M 23 2006 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia 1 🕱 M 2 🗆 F 87 Yre 234-18-2061 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits MD Aberdeen 1⊠Yes 2 No Harford 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 694 Plater Street 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Addie McClure Herbert G. Inghram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Angelini (Daughter) 2206 Grey Fox Ct. Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/06 Parkersburg, W. Va. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Due to (or as a consequence of): Arten Corona Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Syear Failure Kenar resulting in death) Last Due to (or as a consequence of) tF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 90 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 COutpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation м 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Chuck unity one)

Physician /Medical Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit 68760 Box (been signed by the should be detached P.O. Vital Records. page 2 s certificate Hospital or Attending Physician: director. this Division of After thi funeral rector. by the f within 24 hours effer or To the Funerel Direct completely filled in by

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0036

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Funeral

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Physician/Medical

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Medical Certification: To

State Registrar

DHMH 17 Rev 1/2001

FEB 0 9 2006

Kevin

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature Liber &

30. Name and address of perform who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D57456

501 South Union Ave. Havre de Grace, MD

29d. Date signed (Month, Day, Year)

January 23, 2006

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29 2006 10:07A January <u>Helen F. Janosik</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Homewood Retirement Center Williamsport If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Yrs. Director Aug. 18, 1914 Pennsylvania 196-26-0616 Usual Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21795 16505 Virginia Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanya Helen Fabian Michael 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Raffensberger 16968 Edward Doub Rd. Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ 4 Donation 5 Other (Specify) St. Mary's RC Cemetery 2-2-2006 Uniontown, Pennsylvania Asborned Funeral Home, P.A. 21. Signature of Funeral Service License any ir 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the usease, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner HAUNIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗆 Unknown à Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐Yes 2MNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 Yes 2 No filled in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 0-H-0 31. Date filed (Month, Day, Year) , W 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

			1 - For State Registrar	State of Maryland	-	artment rtificate			d Mental Hy	giene	2006	03736
			1. Decedent's Name (First, Middle, La	st)	.				2. Date of D	eath		3. Time of Death
	Physici		Robert Steven J	ones					Month Januar	Day 23	2006	12:15 P M
7	/Medio		4a. Facility Name (If not institution, giv	e street and number)		4b. City, T	own, or Lo	cation of D			County of De	
	C.A.		Frederick Memor	ial Hospital		Frede	erick			1	Freder	ick
	Funeral		5. Social Security Number 6. S		t birthday)	If Under 1	Year If	Under 24	Hrs. 8. Date of Bi		9. B	irthplace (State or Foreign
	Director		225-60-6063	\(\frac{1}{2}\) \(\frac{1}2\) \(\frac{1}{2}\) \(\frac{1}2\) \(\frac{1}2\) \(\frac{1}2\) \(\frac{1}2\) \(\frac	Yrs.	Months	Days I	Hours N	Min. 8. Date of Bi (Month, D Oct. 28	3, 19		Country) rginia
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	e Ma	cto	Maryland Frederi	.ck Midd	letow	m						1 Yes 2 No
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	within 72 hours after deeth with the Maryland ene. than "naturel", or itame 23e or 28e-f ehow the Mudical Exemiter must be notilled at	Funeral Director	01d Nationa	1 Pike		21	769				U.S.A.	
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9	or it	3	1 Never Married 2 Married	1. Yes 2 No		1 🗆 Yes 2	**	Specify:	20110 1 110211, 010.7	1		inte, etc.
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<u>S</u>	should be and Mentel marked o	ပ္	Frank Allen Jones				M	ollie	Marie Mi	nnet	ola	
Maryland	~ ~ ~ ~		19a. Informant's Name/Relationship (Joann L. Jones /						r Rural Route Numb			
	1 end Health em 27 thar tr							LOII K	oad, Fred			
ore	00 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	netery, cren	sition (Name natory or oth	ner place)	i	Date	20c. Loc	cation - City o	or Town, State
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Baltimore,	permit. Peg Depertment Important: f any injury o		21. Signature of Funeral 3 rvice Lice	1590	/ RO	BERTand	Address	Eacility	& SON FUN	FRΔT	HOMES	РΛ
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	Do not ent				diac or respiratory a		,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	illantri	1.11	/A ~	Tarl	21.11	andre			Onset and Death
7	/Medical		resulting in death)	Due to (or as a conseque	nce of):	<i>N</i> -	1000	mice	· cove			
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Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance						2	3d. Date of d	elivery
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σ.	The law requires that the death certifi te has been signed by the attending is age 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the ur	nderlying car	use given i	n Part I.	23e. Did	tobacco us	se contribute	to the cause of death?
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8	w requir been si should	Completed							24a. Was	an	24h Ware	autopsy findings available
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			05 14/						1 Yes	2 No		s 2 No
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ō	Phys this ral di	5 5	1 Yes 2. No 27. Manner of Death	1 Inpatient 2 E	VOutpatien		`		g Home 5 Res			ecify)
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Division	or Attendent efter death Director: in by the	Certification:	4 Homicide determined	building, etc. (Specify)	e, iaiii, 5(ii	eet, lactory,	Onice		City or To	wn, State))	nurar moute ivamber,
-	To the Hospital or Attending Ph within 24 hours eliter death. The Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 € Certifying Ph	ysician: To the best of my knowle	adae doct		t the time	data cod -	loop and due to # :	00115-1-1		
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	ithin o the	Me	29b. Signature and title of certifier	Silva interior stated.		29c	License nu	ımber		29d. Date	signed (Mo	nth, Day, Year)
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7	AVIT		30. Name and address of person who Aimee Park, MD T				0 70 - 1	MT	21702			
			31. Date filed (Month, Day, Year)	homas Johnson D		rred	erick	, MD	Z1/UZ			
	Sta		JAN 2 7	2006 Sz. Herstrar's Signatur	Je .	1 .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** \mathbf{A}^{M} DELICE E. JOHNSON JANUARY 10, 2006 4:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ☐ M 2 👿 F 83 NY 20, 1922 Director 076-14-4942 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ahow. r than "naturel", or items 23e or 28e-f ahov the Medical Examinar must be notified at 1 Yes 2 X No Directo **STEVENSVILLE** QUEEN ANNE'S 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 109 CHESAPEAKE BAY DRIVE USA 21666 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married P. WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental EDGERTON GRANT MIRIAM KLOCK ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 CHESAPEAKE BAY DR., STEVENSVILLE, MD 21666 JEFFREY JOHNSON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER, LLC. 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Importent: If Itel
any injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 LUT Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√20No à been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the f within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29b. Signature and title of Cartifie 29d. Date signed (Month, Day, Year) 132036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Con 32. Registar's Signature 31. Date filed (Month, Da State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Agnes Moore Kavanagh January 22, 2006 3:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 325.26.9490 Yrs. 87 Director Feb.5,1918 New York Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10a. State 10b. County 10d. Inside City Limits •how MD Montgomery Bethesda 1 ☐ Yes 21 No Directo 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a or Examiner must be 9612 Cedar Lane 20814 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced 'naturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Office of President of Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant/Volunteer City College, New York ± 1 other t 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Heelih and Mental Hy Importer; If Item 27 is marked othing any linty or other treumatic event one. 17. Father's Name (First, Middle, Last) Bernard J. Moore Alice McCabe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James H. Kavanagh/ Husband 9612 Cedar Lane Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State National Crematory 1/30/06 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW WDC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bradycardia /Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use i 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1XXIatural 5 Pending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fur death. М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and Ittel of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 22, 2006 1006130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Bethesda, MD 20814 Atul Rohatgi, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 26 2006 Registrar

DHMH 17 Rev 1/2001

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KAVANACH, ACNES

			For State Registrar	State of Marylan		artment of F tificate of			ene 0 0 6	03739
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death	n Day Year	3. Time of Death
	Physici /Medic	al	Mary Catherine			45 City Taylor	r Location of Death	Janua	4. County of De	
	Examin	er	4a. Facility Name (If not institution, give st Washington Count				ge r stown			ington
100	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
jès	Director		219-54-0539 Usual Residence of Decedent	M 2 💢 F 8	3 Yrs.			June 14		Maryland
	yland now at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Washing	nton	На	gerstown				XXYes 2□No
	with th	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (·
	ns 23	Funeral	750 Dual Highway	2. Was Decedent Ever in U.	.S. 13.1	Was Decedent of H	21740 Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		nerican Indian,
036	hours after death with the Maryland lural', or Itams 23a or 28a-f ahow al Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		fYes, specify Cub 1□Yes 2X No		Rican, etc.)	Black, Wh	nite, etc. W hit e
9500-612	72	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ient's Usual Occup	during most of work	king	6b. Kind of Busines	
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מ	filed Hygi sthar	Be Co	17. Father's Name (First, Middle, Last)		146 0	er worke	· · · · · · · · · · · · · · · · · · ·	ne (First, Middle, M		Red
/land	should be nd Mental marked c	To B	James William k	Kirby			Ella	Frances	Barrow	
Mary	C/ 42 = 4		19a. Informant's Name/Relationship (Typ			-			City or Town, State	
	s 1 end f Health Itam 27 other to		Bernadette Gettel - 20a. Method of Disposition			Sition (Name of natory or other pla			Own, MD 21	
D E	9 2 5		XXBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		natory or other pla Cemeter				rt,Maryland
Baltimore,	permit. Pag Department Important: any Injury c		21. Signature of Funeral Service License				unerally Ho		i i i i amspoi	i, nai y rano
n	8828		1 confl (Sh						rt,MD 21795
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent	er the mode of dyn	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
F.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	SV .	4				
	Examiner		A CONTRACTOR OF THE PROPERTY O	MygM	12 u	ie inf	expon	second	any to	
1	Sit ed	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a dónseq	uence of):	resit.	fant		()	
	xecute and al-trans	Examln	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	Son	mywese	ens cu	wence	
28/60	death certificate be executed the attending physician and of for use as the burial-transit		€ a.	Acut	e re	was for	ilure			
	rtificat ng phy s as th	Medical	IF FEMALE:			J				
ROX	eath certiff attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Feta	Ideath 3	Ectopic pregnanc	у		23d. Date of d Month	lelivery Day Year
o.	the de y the a ched f	ysic	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	leath 5∟	Other (specify) _				,
. L	The law requires thet the de tie has been signed by the a bage 2 should be detached (ρ	Part II. Other significant conditions cont	nbuting to death but not res		nderlying cause gr	12 1	11		to the cause of death?
ecords,	w require been si should i	Completed	Planting	16	,	000	34 54	24a. Was ar		autopsy findings available
He	The law sate has page 2	omp	V 323(0) 33 (1)	, , , , , , , , , , , , , , , , , , ,				autops	prior to death	o completion of cause of
Vital R		BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes 2 th (Check only one		33 E- NO
	ding Physician: After this certific funeral director,	2	1 ☐ Yes 2 ☐ Ho		ER/Outpatier	IL 3LI DUA			nce 6 Other (Sp	pecify)
00	Attending Physician: or death. actor; After this certific by the funeral director,	tlon:	27. Manner of Death 1 Accident S Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	nyat rk?]Yes 2 □No	28d. Describe ho	w injury occurred	
Division of	or Attendi after death. Diractor; A in by the fu	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he						Rural Route Number,
ā	Ital or Ature and urs after dried Diract	0	4 Homeda	building, etc. (Specif				City or Town		
	To the Hospital or A within 24 hours after To the Funerel Dirac completely filled in by	edical	29a. Certifier Check only one Check only one	cian: To the best of my known: or: On the basis of examination and manner stated.	wledge, deat ition and/or in	n occurred at the tr vestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th Within To th compl	Me	29b. Signature and attle of certifier	^		29c. Licens	se number	29	d. Date signed (Mo	nth, Dey, Year)
)) ky	- Hicon	D	10	041151	1	Jan. 29	12006
51	4.0		30. Name and address of person who cor	npleted cause of death (Item	1 23a) (Type,	Print) 112	genete	l Cow,	mo 21"	140
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature A A	10.16.2	1	(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** George Frederick Kennedy January 23, 2006 7:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 01ney
If Under 1 Year | If Under 24 Hrs. <u> Montgomery General Hospital</u> 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□ F Months Oct. 8, Director 80 1925 152-16-3939 New Jersey Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Gaithersburg Maryland Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Items 23a or 25004 Woodfield School Road 20882 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, tra Medical Examinarians. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates: WWII 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Manager 12 Westinghouse Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Harry Kennedy 2 Lucille Bruik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17327 19a. Informant's Name/Relationship (Type, Print) Nan C. Fisher - Daughter 5807 N. Church Street, Glen Rock, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Norbeck Memorial Park 1/28/06 Olney, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fun ral Service Licenses Noveri 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pericavdia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ å icate has been sig 7. page 2 should b 2 No 3 Probably 4 Unknown MONONA 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 0 24a. Was an autopsy performed? Yes 2200 certificate has 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes patient 2 ER/Outpatient 3□ DOA Certification: To this ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28a. 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 1 within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifi 29c. License number 2063196 DTIVA 30. Name completed cause of death (Item 23a) (Type, Print) Drive Olva 810 32. Rec State Registrar

			1 - For State Registrar	State of N	Maryland	d / Depa	artmen rtificat	t of H	ealth a Death	and M		iene	J 6	0374	
34	Dharini		1. Decedent's Name (First, Middle, Las	st)		,					Date of Deat Month	h Day	Year	3. Time of D	eath
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	Examir	er	4a. Facility Name (If not institution, give						Location of	of Death		4c. Cour	nty of Deatl	n	
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К	Funeral Director		5. Social Security Number 6. S	ex	Age (In yrs. la	Van	Months	Days	Hours	Min.	8. Date of Birth (Month, Day,	Year)		nplace (State or untry)	Foreign
			464-24-3084 Usual Residence of Decedent		84						AUG 19,	1921	ALAF	BAMA	
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	
	e Ma	ctor	MARYLAND MO	ONTGOMERY			ROCK	VILL	Ε					1 X Yes	2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code			10	0g. Citizen o	of What Co	untry?	
	after death w or Iteme 23a minet must b	ral	14600 WOODCREST DI	Y					20853				U.S.A		
	ltem Item	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force: 1 ☐ Yes 2 ☐	<u>s?</u>	5. 13.	Was Dece If Yes, spe	dent of Hi cify Cubai	spanic Ori n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		ace - Ame lack, White	ncan Indian, e, etc.	
39	urs af	by F	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates			1 🗌 Yes	2 🗓 No	Specify:			Spec	city:	WHITE	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Iteme 23a or 28a-f show other then "natural", or Iteme 7 half be mailied at	ted	15. Decedent's Ed				dent's Usu			A = (16b. Kind of	Business/	industry	
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7	ed wi	Con	12				HOME	MAKE				OWN H			
and E	be fill	Be	17. Father's Name (First, Middle, Last) LEON MEYER								(First, Middle, N	Maiden Sum	ame)		
7	hould d Mer marke matic	2	19a. Informant's Name/Relationship (Tuna Print)		10b Maili	na Addron	/Stmata		IA SA	Route Number,	City of Tou	m State 7	in Code)	
Maryland	d 2 s th an th an traur		SALLY L. BURG/DAUG								ROCKVILI				3
	Heal Heal tem 2		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Na	me of				20c. Locatio			
OE.	Pages ent of tr: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		e	metery, crei 'ROPOL'	-			1/2	4/2006 A	LEXAN	DRIA.	VIRGIN	IA
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other fraumatic event, ILEM, once.		21. Signature of Furteral Service Licer		ı	2:	2. Name ar	nd Addres	s of Facilit	ty	_				
m	Depar Impor any ir		(an)								MEMORIAI ROCKVI				52
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	Physician		Immediate Cause (Final disease or condition	a END ST	AGE IS	CHEMI	C CAR	DIOM	YOPAT	'HY				Onset and De	
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. ¥	* *	<u>_</u>	Sequentially list conditions,	b. ATHERO	SCLERO		EART	DISE	ASE_					YEARS	
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				DM							WEADO	
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9	certificate be executed Iding physicien and Ise as the burial-transit	ledi													
Вох	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic p	reonancy					Date of deli		
	e death he atter hed for u	sicis	in the past 12 months? 1 \(\sum \text{Yes} 2 \) \(\sum \text{No}\)	4□Pregnant 9□Unknown	at time of de		Other (sp			<u> </u>			Month	Day Ye	ear .
P.O.	that the de led by the a detached f	Completed by Physician/Me	9 ☐ Unknown Part II. Other significant conditions of	contribution to death	but not con	Iting in the u	adorbina s		n in Dart I		23a Did tob	2000 1100 00	antábuta ta	the cause of de	nth?
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5	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	itient 2 🗆 E	ER/Outpatie	nt 3 DC	Othe			<i>(Check only on</i> ne 5 ☐ Reside		Other (Spec	ASSIS	GED -
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Division of Vital Record	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At horests. (Specify	me, farm, st	reet, factor	y, office		2	8f. Location (St. City or Town		mber or Ru	iral Route Numb	er,
0	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		00- O-19	1											
	Hospital of 24 hours at Funeral Detely filled i	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysician: To the be miner: On the basis	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the tim , in my or	ie, date an pinion, dea	nd place, a oth occurre	nd due to the ca d at the time, da	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)	
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	- 5 - 0		Shama R.	Mittal	inu			DOO	61202						
	10		30. Name and address of person who	completed cause o	f death (Item	23a) (Type.	Print)	וטטע	61382			JANUAR	.1 23,	2006	
			DR. SHAMA MITTAL,		•			UITE	152,	ROCE	KVILE, N	1ARYLA	ND 2	0850	
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1.0	Regist	eli.	JAN 261	LUUD Man	Leen A										

			For State Registrar	State of Mary		artment of He rtificate of D		ntal Hygien	UUU	03742
ì	Physici /Medic		1. Decedent's Name (First, Middle, Las Roberta Leo	age:++				Date of Death Month	ž ačte	3. Time of Death
	Examin	_	4a. Facility Name (If not institution, gived University of Mary) 5. Social Security Number 6.5	and Medical	Center yrs. last birthday)		re	Date of Birth	County of Dear	the City tholace (State or Foreign
	Director		212-50-9090	□ M 2XF 5		Months Days	Hours Min.	(Month, Day, Year June 15 1	Co	ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	a-feh	ctor	Maryland Washin	gton	Hagers	town				1 X Yes 2. No
	with the	Director	10e. Street and Number 16816 Alcott Ro	De		10f. Zip Code 217	740	10g. C	itizen of What Co	ountry?
	me 23	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. 1	Was Decedent of His If Yes, specify Cuban,		y Yes or No-	U.S.A.	nican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "natural", or items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be maillished at once.	þ	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Your lif Yes, Give Year or Dates:	ļ	If Yes, specify Cuban, 1□ Yes 2XNo	, Mexican, Puerto Ric Specify:	an, etc.)	Black, Whit	e, etc. hite
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힏	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)				8. Mother's Name (F	irst, Middle, Maide	n Sumame)	c Company
Maryland	ould b	70	George R. Rowe					a Catheri		
Mai	d 2 sh th and t7 is m traum	N	19a. Informant's Name/Relationship			ng Address (Street an				
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altimore,	Page ment c ant: if ury or		1 ∏Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi	Removal from State //		en Cemeter		6 Ha	gerstow	n Maryland
Ball	permit Depart Import eny in		21. Signature of Funeral Service Licer	1. Liny	11	2. Name and Address 331 Easter	Doug.	las A. Fi . Hagerst		eral Home Vland 21742
H			23a. Part1. Enter the disease, or com shock, or heart ailure. List only	one cause on each line.	death. Do not ent	ter the mode of dying,	such as cardiac or r			Approximate Interval Between Onset and Death
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ا م	g Phy ter this neral d		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	" 3D DOX	4 Nuising Home	5 Residence d. Describe how inju		city)
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ΟĬ	i or Attend efter death Director: /	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, office	281	f. Location (Street a City or Town, Sta		ural Route Number,
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred at the time vestigation, in my opli	, date and place, and nion, death occurred	d due to the cause(at the time, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
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61	4-3		30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Street Pr	Himore +			
	Sta	ite	31. Date filed (Month, Day, Year) JAN 3 1 2	32. Begistrar's S	Signature	J. 3.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	17 0100	•	
	Registi	ar	JAN 31 4	100 Decem	D. Sop	eres				

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dennis Clifford Loy 14, 2006 Jan. 6 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16846 Longfellow Ct. Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 218-50-3510 1**X** M 2□ F Director 51 16, 1954 Usual Residence of Decedent filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic event, the Madical Examinar must be notified at MD Washington Director 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16846 Longfellow Ct. 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hill left if item 27 is marked oth Malcolm L. Lov Hattie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Loy (Wife) 16846 Longfellow Ct., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permi. Page Department of Important: if any injury or once. 4 Donation 5 Dther (Spacify) Lutheran cemetery 1/17/06 Jefferson, MD ature of Funeral Service BonaTd dd Bs of Thompson Funeral Home 31 E. Main St., Middletown, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MTOCKRUIN INFARCTION disease or condition resulting in death) /Medical **Examiner** METERIOSCLEROTIC CHROLOVASCULAR DISEASE HANY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physiclen Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ∏ Yes 2 ∏ No director 25. Was case referred to medicat 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide hin 24 hours a 1. Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01667 MI 18,2006 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 31. Date filed (Month, Day, Year) JAN 1 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene () () 03766 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** LEWIS WILLIAM HOLTON 2006 4:00 PM JAN. 11 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Oeath Examiner **OUEEN ANNE** CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Days Hours Min. Months 10XM 2□ F MAR. 17, 1922 MARYLAND Director 83 218-24-2772 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene int: If item 27 is marked other than "natural; or Iteme 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Iteme 23a or 28a-f show 1 ☐ Yes 2X No **QUEEN ANNE** STEVENSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21666 200 TERRAPIN GROVE, APT. 223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: UNK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð WHITE 3 X Widowed 4 ☐ Divorced Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAFOOD WATERMAN 6 traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be THOMPSON CORA LEWIS FRANK 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 CARTER ROAD, CHURCH HILL, MD 21623 MRS. PATI STADDEN other 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. STEVENSVILLE, MD ö STEVENSVILLE CEMETERY 1-17-2006 5 Other (Specify) 21. Signa fund of Funeral Service Light 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 VI 11/00 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Examiner KUDS GENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, nutcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending Injury 1 🗌 Yes 2 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 1 3 2006 32. Registrar's Signature State Registrar

Brent 06-00 CT	: L. McD)748)on	ald Unpend item#23a,27 1- State	e Type or ,28a I,pen State o	Print in I E. G852, If Marylar					All Cop Mental	ies Ar Hygie	re Legil	ole.	0271.5
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2	Funeral Director		•	3. Sex 1 [3] M 2 □ F	7. Age (In yrs.	Vrc		Days	If Under 24 Hrs Hours Min.	. (Mon	of Birth th, Day, Ye	ar)	9. Birthp	lace (State or Foreign try)
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	the M 286-1	Director	VA 10e. Street and Number		Al	exandı		Code			10-	033		1 LYes 2 No
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		1	1 - For State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygie	ZIIIIb IIRTAB
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medic		Julia Margaret McIntin 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Februar	1, 2006 7/10 A M
	Examin	er	23 Drake Road	Chesapeake City	,	Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Il Under 1 Year If Under 24 Hrs.	8 Date of Birth	9 Birthplace (State or Foreign
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/	acute ind trans	Examiner	that initiated events c.			
8760,	cien a		Due to (or as a consequence of):			
87	death certificate be executed e ettending physicien and id for use as the burfal-transit	Physician/Medical	d			
9 X	eath certific ettending p for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	eath etten for u	cian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.		ysi	1 Yes 2 No 9 Unknown			
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	quire n sig				1 ☐ Yes	2 No 3 Probably 4 Unknown
S	aw requir	Completed			24a. Was an	24b. Were autopsy findings available
æ	9 - 6	Eo			autopsy performe 1 ☐ Yes 2(2	d? prior to completion of cause of death? No 1 □ Yes 2 □ No
ita	ilcien: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death		
>	<u>v</u>	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 Residenc	ce 6 DOther (Specify) 5/3/24/3
0	ding Ph n. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time	Work?	28d. Describe how	injury occurred
SiO	Attending in death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	or Attendation of the Control of the	Certification:	4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	City or Town, S	et and Number or Rural Route Number, State)
_	Hospitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the caus	ca/c) and manner ac stated
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To the within 2 To the comple	₩ We	29b. Signature and title ol certifier	29c. License number	29d	. Date signed (Month, Day, Year)
			N Tarkos, Mo	171531	4 F	ebruar 2. 2006
•	0		30. Name and address of person who completed cause of death (Item 23a) (Typ.	e, Print)	1	
	2		It Farkos MD Seasons	Hospice Elkto	on My	
	Sta		2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Typut Fay 65 M) 31. Date filled (Month, Day, Year) FEB 0 9 2006	ء مِدَّة		
	Regist	rar	LED O 9 COOD Live of the			

Registrar

	-	Plea 1 - State Registrer	State of M		/ Depa		of Hea	alth and M	•		006	03748
Physicia /Medica	n al	1. Decedent's Name (First, Midd Bennie L. McC	Cray						2. Date of De Month Januar	aath Y 17	, 2006	3. Time of Death 7:01 AM
Examine		4a. Fecility Name (If not institution Prince Georges	Hospital			Cheve	erly	cation of Death		P	County of Death	eorges
Funeral Director		5. Social Security Number 423–20–8524 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. Ias 8	of birthday) 9 Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bi	av. Year)	9. Birth Cool Bull Alak	place (State or Foreign Intry) Lock County
e Maryland la-f ehow	ctor	DC 10a. State 10b. County	/		Town or Lo							10d. Inside City Limits 1 XYes 2 No
23a or 26	Funeral Director	10e. Street and Number 1515 Ogden St.	NW #222			10f. Zip 0	010			Uni	ted Stat	•
urs a	۵	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorced	If Yes Give 7	?] No		Was Decede If Yes, specif 1 ☐ Yes 2[anic Origin? (S) Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify: Bla	, etc.
within 72 hc ene. 'then "natur	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 8th	nt's Education est grade completed) College (1-4or	5+)			Occupation during retired)	n ng most of wor	king	La	ind of Business/liborers I	
ould be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Hayward McCr			Labor	CI		B. Mother's Nan Bessie	ne (First, Middle Thornto		Sumame)	
end 2 sho aalth and n 27 le mu		19a. Informant's Name/Relations Sandra L. McC		ghter						-	or Town, State, Zi n , DC 20	
Peges 1 e		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (3		_ сеп	ce of Dispo	osition (Name matory or oth Ceme	e of ner place)	1	Date 26/06	20c. L	ocation - City or T	
permit. Departr Imports eny trij		21. Signature of Funeral Service	all-		I I	3821 1	Roys	ster Fu	neral Ho W Wash	inota	on, DC 2	0011
Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or head failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Hyper		Do not ent	er the mode	of dying, s	r Disea	or respiratory a	arrest,	, 20	Approximate Interval Between Onset and Death
be executed iicien and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	s a conseque								
W 2 M	Physician/Medic	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal d	leath 3	Ectopic pred					23d. Date of delin	very Day Year
quires thet in signed b uld be dete	۾	Part II. Other significant condit	ions contributing to death state, Diabet				use given i	n Part I.				the cause of death?
The law re sete hes bee page 2 sho	Completed								24a. Was auto peri 1 🗆 Yes		prior to co	opsy findings available ompletion of cause of
sician: certific irector,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 X No	al Hospital: 1 ☐ Inpa	tiont MTC	R/Outpatier	nt 3 DOA	0		th (Check only		6 □Other (Spec	
anding Phy ath. or: Atter this	ation: To	27. Manner of Death 1 XNatural 5 Pendi 2 Accident invest	28a. Date of In (Month, C	jury 2	28b. Time o Injury		c. Injury at Work?		28d. Describe			7)
Ital or Atterns after de rel Directo	Certification:	4 Homicide	mined 28e. Place of it	etc. (Specify)					City or To	wn, State	e)	ral Route Number,
e Hosp 24 hou e Fune letely fil	edicai	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☐ Medica	ing Physician: To the bes I Exeminer: On the basis and manner:	of examinatio	ledge, deat on and/or in	h occurred at vestigation, i	t the time, in my opini	date and place on, death occu	, and due to the rred at the time	cause(s , date an	s) and manner as d place, and due	stated. to the cause(s)
To th To th	ž	29b. Signature and title of certific	or OVV			29c.	License ni		4	29d. Da	ate signed (Month	
5		30. Name and address of person Anthony Ibe	n who completed cause of , M.D. 1160	death (Item 2) Varnu	23a) (Type, um St.	Print) NE		30564 Washii	ngton, I	DC 20	/ /20 / 0017	00
Stat Registra		31. Date filed (Month, Day, Year JAN 2	r) 32 Regis	trar's Signatu		orle			-3-0-11, 1			

			For State Registrar	State of M	aryland	-	artment o				giene Reg. No.	006	03749
	Physicia	212	1. Decedent's Name (First, Middle,	,						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Rachel		shak					anuary	20,	2006	3:15 A M
}	Examin	er	4a. Facility Name (If not institution, Manor Care Pote)		4b. City, Tow	n, or Location ac,Ma:		ı		County of Deatl ntgomer	
	Europe				ge (In yrs. la	st birthday)	If Under 1 Ye			8. Date of Birt	th	9. Birth	nolace (State or Foreign
L	Funeral Director		054-22-7488	1□M 2 X F	99	Yrs.	Months Da		Min.	(Month, Da uly 12	y, Year) 19	06 Russ	untry)
	p ,		Usual Residence of Decedent		10- 65	Town or Lo							
	shov	٥ľ	10a. State 10b. County Maryland Montg	omerv	_ "	omac	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	the h	Director	10e. Street and Number				10f, Zip Coo	Α	-		10a Citiz	en of What Co	
	3a or	I Di	10714 Tennis La	ne				354		İ	_	ed Stat	-
	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or frems 23e or 28e-f show marked other than "natural", or frems 25e or 28e-f show maile event, If e Mindred Examiner must be neitified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	13.	Vas Decedent f Yes, specify (of Hispanic O	rigin? (Spec	ify Yes or No	- 1	4. Race - Amer	
9	after or Ite	/ Ful	1 Never Married 2 Marrie	d 1 Tyes 2 Ty			1 Tes, specify 0 1 □ Yes 2 💢			ican, etc.)	1	Black, White Specify: W	a, etc. Thite
8	hours ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:									
<u>.</u>	n 72 nat	Completed	15, Decedent's (Specify only highest	grade completed)		16a. Deced (Give	ient's Usual Oc kind of work do DO NOT use re	cupation ne during mo tired)	st of working	7	16b. Kin	id of Business/I	Industry
212	i with liene. r than	omp	Elementary/Secondary (0-12) 12	College (1-4or	5+)		sewife				ow	n home	
פ	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, La	ast)						First, Middle,		Sumame)	
<u>a</u>	should be nd Mental marked o	To	Elya Kone					Sla	va Lub	oshitz	<u> </u>		
a L	2 E 2 2		19a. Informant's Name/Relationshi	c) (Type, Print)			_				-	Town, State, Z	
e G	l and lealth im 27 her tr		Albert Marshak-	son	20h Bla		Park S sition (Name of		Atlar			NY1150	
5	Pages nent of H		20a. Method of Disposition 1	Removal from State	cer	metery, cren	natory or other	olace)				ation - City or I	
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any injury c		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li		Mot	unt Ar		dress of Eaci					, New York
B	Departiment Depart		21. Signature of Furieral Service En	261366								berg Me	morial le, MD20852
			23a. Part1. Enter the disease, or c	omplications that cause	d the death.							ROCKVII	Approximate
J.	Physician		shock, or heart failure. List or Immediate Cause (Final			- 6	Lover	Die	2 - 1 6	?			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Coron Due to (or as	a conseque	ence of):	1649	٥١٥	ease	-			014
	Examiner		Removationly list a virthic val.	ath-	e vos	cleva	2180						ald.
K.U.	D is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	V						00-1.
	and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to or a	a conseque	ance of):	1707						0901
8760,	ate be executed hysician and the burial-transit											-	
68/	ate hy	edical		o									
Rox	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catania aragna				23	3d. Date of deli-	very
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 🔯 No	1 □Live birth 4 □Pregnant a 9 □ Unknown]Ectopic pregna] Other <i>(specif</i> y					Month	Day Year
J O	at the de	Phys	9 ☐ Unknown ¯										
Š	requires that the een signed by th nould be detache	by	Part II. Other significant condition	s contributing to death t	out not result	ting in the ur	iderlying cause	given in Part	I.		obacco us		the cause of death?
Vital Record	w requi	Completed	advanced	1 9 11	C	- 0-		4.5.54	0				
Žec	has has	mpi	_ Cerebra	1		cler	oses	WIT	n	24a. Was autop	SV	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
B			Vascular 25. Was case referred to medical	disease	1.					·	med? No	1 ☐ Yes	2□ No
		То Ве	examiner?	Höspital:	ent 2 E	R/Outnation	3 DOA	Othor		Check only o		☐Other (Spec	i64)
Division of	g Phys ter this neral di		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		njury at Vork?		d. Describe h			119)
Ö	E & 2 ii	atio	1 X Natural 5 ☐ Pending investiga	tion	ly / Gai/	пциту		Yes 2]No				
<u> </u>	or Attendations after deati	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of in	jury - At hom tc. (Specify)	ne, farm, str	eet, factory, offi	ce	28	of. Location (5 City or Tox		Number or Ru	ral Route Number,
	Hospital or 24 hours afte Funaral Dir tely filled in i								- 71				
	• Hosi 124 ho • Funti letely f	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner st	of examination	rledge, death on and/or inv	n occurred at the restigation, in π	e time, date a ly opinion, de	nd place, an ath occurred	d due to the d at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	o the within 2 To the complet	Me	29b. Signature and title of certifier	and mainter of			29c. Lic	ense number			29d. Date	signed (Month	, Day, Year)
6	5) "		Aco 1	in l	D		D 3	3131	9		1-	20-0	06
	-V		30. Name and address of person w	no completed cause of	death (Item 2	23a) (Type,	Print)		•				
			DR. LORETO S. AL	BIOL, 8218	WISCO	NSIN	AVE, #3	05, BE	THESDA	, MD	2081	4	
	Sta	_	31. Date filed (Month, Day, Year)	2006 32. Rigist	rar's Signatu	% A	partes						
	Registr	ar	OHN S	1	3000	- 7							

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

7

2006

32. Registrar's Signature

d.	L		State of Mar 1 - State Registrar			rtment of H		and M		iene	06	037	51
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of	Death
	Physici: /Medic		John Robert Norris						Februar	y 1,	2006		РМ
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or		of Death			unty of Death Mary ^t		
			24598 Hollywood Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthe	dayl	Hollywo	If Under:	24 Hrs.	8 Date of Birth			place (State or	r Foreign
	Funeral Director		216-70-9912 1½M 2□F	48 Yr		Months Days	Hours	Min.	8. Date of Birth (Month, Day July 5,		Cou	ntry) vland	1 or olgin
			Usual Residence of Decedent						July J				
	anylan show	_	,	10c. City, Town o								10d. Inside Cit 1 ☐ Yes	
	Ne Mi	ecto	Maryland St. Mary's		Но	11ywood				Og Citizen	of What Cou		
	with t	Dir	24598 Hollywood Road			206	636			og. omzon	USA		
	death me 23	era	11 Marital Status 12. Was Decedent Ev	rer in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba		gin? (Spe	ecrfy Yes or No-		Race - Ameri		
9	or ite	F	1 Never Married 2 Married 1 Yes, Give	JI .		Yes, spectry Cuba □ Yes 2X No	n, mexicar Specify:		rican, etc.)		Black, White, ecify: Wh	, etc. nite	
003	72 hours after death with the Maryland Insturat; or Iteme 23s or 28s-(show disal Examinat must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:										
15-	n 72 i	lete	15. Decedent's Education (Specify only highest grade completed)		Give .	lent's Usual Occupa kind of work done o DO NOT use retired	during mos	t of worki	ing	160. Kind C	of Business/Ir	idustry	
212	I with	omp	Elementary/Secondary (0·12) College (1-4or 5+)		Ну	pnotist				Self	Employ	yed	
פַ	e filec at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden Sur	пате)		
ylaı	Menta Menta arked	To	John Arthur Norris						n Louise				
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Print) Mary Jeanette Norris / Wife			g Address (Street a						p Code)	
	1 and Heelth em 27 ther t		20a. Method of Disposition	20b. Place of D	Dispo	sition (Name of		-	Date		ion - City or T	own, State	
nor	ages ant of it: If It y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place in Cremator		Feb 3	, 2006	Alexa	ndria,	, VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "natural," or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be nutited at ADEC.		21. Signature of Funeral Service Licensee		22	. Name and Addres	lev-Gar	rdine	r Funeral	Home,	P.A.		
	40140		23a. Part 1. Enter the disease, or complications that caused to	he death. Do no	ot ente				ardtown, l		.0	Approximate	9
	Physician		shock, or heart failure. List only one cause on each line Immediate Cause (Final	9 1.	41	1 0.	, 11	0				Onset and I	
	/Medical		disease or condition resulting in death) Due to (or as a	consequence of	1 4 f):	Joury 9	Pu	-					
	Examiner		Sequentially list conditions, b.		v	V							
	₽ # <u>#</u>	Iner		consequence of	1).								
	and and I-trans	Examiner	that initiated events c.	consequence of	f):			_					
8760,	icate be executed physician and s the burial-transit	ical E			.,.								
687	death certificate be executed e attending physician and id for use as the burial-transit	ed	d										
Box	eath certific attending p	Z/M	1F FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		3.	Ectopic pregnancy	,			23d	. Date of delin	•	
-	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti			Other (specify)	· · · · · · · · · · · · · · · · · · ·				Month	Day *	rear .
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but	not regulting in	tha	ndarking agusa gu	on in Part I		23e Did to	hacco use	contribute to	the cause of c	leath?
	Se De es	þ	Part II. Other significant conditions contibuting to dealif but	not resulting in	u lo ul	iloenying cause giv	en air air		1 🗆 Y				Jnknown
Sor	w requir been si should	eted							24a. Was	an 2	4b. Were au	topsy findings	available
Vital Records,	The lay	Comple								sy med?	prior to c d ath? 1 Yes	ompletion of c	ause of
ta		0	25. Was case referred to medical				26. Place	e of Deat	1 (Check only o	2□No ne)	91163	2 140	
Ϋ́	®	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	t 2 EFVOutp	patier	at 3 DOA Oth	er: 4 🗆 Nu	ursing Ho	me 5 Resid	lence 6 🗷	Other (Spec	sty) scen	e
n of			27. Manner of Death 28a. Date of Injury (Month, Day	Year) 28b. Tin	ime of	Wor		/	28d. Describe h	low injury or	ccurred		
sio	or Attending after death. Director: Afte in by the fune	catl	2 ☐ Accident investigation Found will		105	7045	Yes 2	No	28f. Location (S		tumbo or Pu	m / Pouts Alum	hor
Division	l or Atten after deat Director:	Certification:	3 Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of Injur building, etc.	(Specify)		he at resi	duc.		City or Tou		24598	Hollyn	
	To the Hospital or I within 24 hours after To the Funerel Directon pletely filled in b		29a. Certifier 1 ☐ Certifying Physician: To the best of	my knowledge,	deati	n occurred at the tir	ne, date ar	nd place,	and due to the	ause(s) and	d manner as	stated.	
	ne Hos	Medical	(Check only 2 Medical Examiner: On the basis of and manner state	examination and	Vor in	vestigation, in my o	pinion, dea	ath occur	red at the time,	date and pla	ace, and due	to the cause(s	5)
	To the vithin 2 To the complet	ž	29b. Signature and title of certifier			29c. Licens	e number				igned (Month		
			Throdere U. Hira	wo		OCME]	Februa	ary 2,	2006	
			30. Name and address of person who completed cause of de	ath (Item 23a) (T	Туре,		a :		D 1. 1	3.6		1 01001	
a	Sta	nto-	31. Date filed (Month, Day, Year) 32. Pagistra	r's Signature		111 Penn	Stre	et,	<u>Baltimo</u>	re, Ma	iryland	1 21201	
24	Regist		FEB 0 3 2006	e &	1	mark!							

			. Por	partment of Health and Mertificate of Death	ental Hygie	4000	03752
	Physici	an	1. Decedent's Name (First, Middle, Last) Mildred Katherine Nolan		2. Date of Death Month January	Day Year 31, 2006	3. Time of Death 5:30 P M
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of Death	
(a)	Lamin	Ĭ	St. Mary's Nursing Center	Leonardtown		St. Mary's	3
K:-	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 110-26-3342 7. Age (In yrs. last birthda) 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 10, 1	ear) Cou	place (State or Foreign ntry) cticut
	land Dw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location			10d. Inside City Limits
	Mary Fe sh	ţō	Maryland St. Mary's Leonar	dtown			1 □Yes 2 No
	or 28g)irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	ath w	rai	22210 Bull Road	20650		USA	
36	72 hours after death with the Maryland 'natural', or Itema 23a or 28a-f show dical Examinat must ba notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2XXNo Specify:	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Items 23a or 28a-f show apprintury or other traumatic event, the Medical Exemination at Angle.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ng	b. Kind of Business/Ir	
q 5	filed v Hygie ther t		12 2 1' 17. Father's Name (First, Middle, Last)	eacher 18. Mother's Name		School iden Sumame)	
an	lid be ked o	To Be	George Steven Shea	Mary Agne	s Dovle		
ary	and M	-		ling Address (Street and Number or Rura		City or Town, State, Zi	o Code)
≥,	and 2 ealth m 27 i			Newtowne Neck Road, Led			
imore	Pages 1 menf of H ant: if ite		Trinity Me	ematory or other place) Febru	ıary	c. Location - City or T	
Ball	Departition Depart		Mechael Xelita Harde & P	22. Name and Address of Facility attingley-Gardiner Fune .O. Box 270, Leonardtown	ral Home, F n, Maryland	A. 1 20650	
) y	Pnysician /Medical		23a. Part1. Enter the disease, of complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due t (or as a consequence if).	nter the mode of dying, such as ardiac of	r respiratory arrest		Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dicai Examiner	Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):	althrondr	Ha)		Says -
.O. Box 68	death certifi e attending I od for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
s, P	8 5 0	ğ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?
Vital Record	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe	d? prior to co	opsy findings available ompletion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
o	ing Phys n. After this funeral dii	ation: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Actival 5 Pending 2 Accident investigation Hospital: 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 2	ne 5 Residence 8d. Describe how	ce 6 Other (Speci injury occurred	(y)
Division	tal or Atte s after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dei (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within To the comple	ž	29b. Signature and title of partifier Ama J. F. Jan J. J.	29c. License number D 06419	290	Date signed (Month)	Day, Year)
			30. Name and address or reson who completed so of death (Item 2 a) (Typ	S1407A 20	0000		
15.	Sta	to.	James P. Jarboe, M.D. 24035 Three Notch Road 31. Date filed (Month, Day, Year) Agistrar's Signature	, Hollywood, Maryland 20	1636		
1	Regist	-04	FEB 0 3 2006	ME			

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 6 0 3 7 5 3
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) EVELYN ELBEN PALMATARY 2. Date of Death Month
	Funeral Director		CHESTER RIVER MANOR CHESTERTOWN S. Social Security Number 217-14-8733 CHESTERTOWN CHESTERTO
	the Maryland 28a-f show	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic svent, the Medical Evaluins must be nutified at ODGE.	by Funeral Dir	2095 CEDAR HILL PARKWAY 11. Marital Status 1
Maryland 21215-0036	ad within 72 hou giene. er then "natura i, the Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARM OWNER AGRICULTURE
aryland	should be file and Mental Hy s marked oth umatic svent	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSA MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, M	Pages 1 and 2 ent of Health ant: If item 27 I ry or other tra		JUNE HARVEY / DAUGHTER P.O. BOX 105, BIVALVE, MD 21814 20a. Method of Disposition \(\frac{\text{X}}{\text{Burial}} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) \(\frac{\text{X}}{\text{Burial ponation}} \) 5 \(\text{Other (Specify)} \) \(\frac{\text{CREEN MOUNT CEMETERY}}{\text{CEMETERY}} \) 1-17-2006
Balti	permit. Depertm Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only on so n each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
68760,	cate be executed physiclan and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.
.O. Box 6	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes
Records, P.	v requir been s should	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? CPYEDYUULIUM OF (1 Yes 2 No 3 Probably 4 Dunknown 24a. Was an autopsy prior to completion of cause of
Vital	iclan: certifica rector, p	o Be	autopsy period to completion of cause of death? 1
Division of	ding h. After fune	ertification: T	Manner of Death Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Comparison Natural Natural Comparison Natural Na
۵	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fi	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the date of the cause(s) and manner as stated. Consider the time, date and place, and due to the cause(s) and manner as stated.
)	To the To the Complete	W	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month/Day, Year) 39. Name and address of person who completed caure of death (Item 23a) (Type, Print)
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 7 2006 JAN 1 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per in 832 2-9-06 vt.

State of Maryland / Department of Health and Mental Hygiene 0 6 For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29, 2006 5:45 AM Jan. Gladys Eloise Rauh 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Oak Crest Village Parkville 8. Date of th (Month, Bay, Year) May 30, 1908 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours 1□M 2X F 97 220-24-4807 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 8832 Walther Boulevard 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William J. Baer Rosa Ely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Rauh, Grandson 7316 Lunt Ave., Chicago, IL 20b. Place of Disposition (Name of cometery, crematory or other place)
Pine Grove United
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Feb. 1 X Burial 2 Cremation 3 Removal from State 2006 Parkton, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice service 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. a Centre 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a jury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Examiner The law requires that the death certificate be executed Box 68760, o Division of Vital Records. or Attanding death. To the Hospital o within 24 hours aft To the Funeral Di

Physician

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Funeral

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Baltimore, Maryland 21215-0036

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Monics 31. Date filed (Month, Day, Year) FEB 0 9 Registrar

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boolesiag)

29c. License number

D5864

Parlau.

29d. Date signed (Month, Day, Year)

30

2006

			For State Registrar	State of N	Maryland		irtment of H tificate of I		_	giene Reg. No.	006	03755			
	3	2	1. Decedent's Name (First, Middle	Last)			-		2. Date of De.	ath Day	Year	3. Time of Death			
	Physici /Medic		BEATRICE SHEL!	ION ROBINS	ON				January		300€	2100 PM.			
	Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, or	r Location of Dea	th	4c.	County of Dea	th			
			WASHINGTON COU	NTY HOSPITA	L			HAGERS'	STOWN			SHINGTON			
	Funeral Director		5. Social Security Number 400–28–5016	6. Sex 1 □ M 2 X 7. /	Age (In yrs. Ia: 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	v. Year)	9. Birthplace (State or Foreign Country) 5. 1922 KENTUCKY				
7	D .		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Lo	anting					10d. Inside City Limits			
	anyla shov	-			Toc. City,	TOWN OF LO						1 XYes 2 □ No			
	89-f	Director		ASHINGTON			1	ONSBORO							
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	ath v	ra	141 S. MAIN STI			1.0.1		21713				S.A.			
21215-0036	within 72 hours after death with the Maryland iene. rithen "nature!", or iteme 23e or 28e-f show the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Tyes 2 Il Yes, Give Year or Dates	\$? X No	i	Vas Decedent of H I Yes, specify Cuba I□ Yes 2 XNo	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHITE				
Ö	72 hor	ted	15. Decedent					ation		16b. Kir	nd of Business	/Industry			
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, Maryland	nd 2 sho alth and 27 is m r treum	•	19a. Informant's Name/Relationsh BRENDA R. CUNN		CE		g Address (Street a					^{Zip Code)} VIRGINIA 254(
Baltimore,			20a. Method of Disposition	0 []D	0.00	netery, crem	sition (Name of natory or other place	:e)	Date	20c. Lo	cation - City or	Town, State			
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	Fig. 5		23a, Part1. Enter the disease or	complications that caus	ed the death.	Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between			
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ă	death atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant			Ectopic pregnancy Other (specify)				Month	Day Year			
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	o tha o tha omple	Me	29b. Signature and title of certifier	1			29c. License	e number		29d. Date	signed (Mont	h, Day, Year)			
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1	11.10		30. Name and address of person v	1-	death (Item 2	23a) (Type, I	Print)	. 1.	1 1	I	9) / 7 1	-1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03756 State of Maryland / Department of Health and Mental Hygiene U U 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month een 252026 Keamo 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Glade Valley Nursing Home Walkersville 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min. 1□M 202F 214-32-9598 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐ No Frederick Walkersville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 500 Chapel Court 21793 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Associate 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Sears Algeron P. Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21702 Eileen Joy - Daughter 6807 Sunnybrook Drive, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-28-2006 Parklawn Memorial Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home (allike | 1621 Opossumtown Pike, Frederick, Maryland 21702 Maron amella 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (r as a nsequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit The law requires that the death certificate be executed ed by the a is been signed by the should be detached page 2 certificate or Attending Physician: completely filled in by the funeral director, this After after death. within 24 hours a To the Funeral D

Physician

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Funeral Directo

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Medical Certification: To Be

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

12 should be filed w and Mental Hygier 7 is marked other th

Pages 1 and 2 s ment of Health an ant: If item 27 is 1

Department of Important: If it any injury or once.

Physician /Medical Examiner

State

Date filed (Month, Day, Year) Registrar

(Check only one)

29b. Signatur, and title of certifier

empleted cause of death (frem 23a) (Type

32. Raistrar's Signature

JAN 2 7 2006

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 03757 For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 23 2006 4:08 P M Shirley Dena Cohen Seeman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring 3154 Gracefield Road #205 It Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F Yrs 87 Director 219-10-6443 Sept. 23 1918 Baltimore, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show injury or other traumatic event, the Medical Exeminar must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2x No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itema 23a or United States 20904 3154 Gracefield Road #205 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Itema 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursery School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Sindler Ralph A. Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 te any injury or other training. 3154 Gracefield Road, #205, Silver Spring MD 20904 Isadore Seeman, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Judean Memorial Grdn | 01-25-2006 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home Inc. 21. Signature of Funeral Service Licept 11800 New Hampshire Ave Silver Spring MD 20904 anuell lla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Hodgkin's Lymphoma Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2x No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🔯 Na Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12 D45880 January 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, MD Leon C. Hwang, M.D. 31. Date filed (Month, Day, Year) State **JAN 26** 2006 Registrar

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	() <u>.</u>		Decedent's Name (First, Middle, Last)			2. Date of Death	Dav Year	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	•	4c. County of Death	
95		gy t	Washington County Hospital	Hagersto	own.	V.	Vashingtor	County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days	Hours Min.	(Month, Day, Yea	ar) 9. Birth	place (State of Foreign intry)
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d, Inside City Limits
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	the 128a-	ec.	10e. Street and Number	10f. Zip Code		10g. (Citizen of What Cou	ntry?
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	hours after death with the Maryland tural', or Items 23a or 28a-f show at Exeminar must be notitied at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Spec	cify Yes or No-	14. Race - Ameri	
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2	Hygie Hygie other t	S	17. Father's Name (First, Middle, Last)		18. Mother's Name			Jveriment
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$\frac{3}{2}$	nould be d Mental narked o natic sve	10	James Shull 19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Street ar	Edna Cur		C4-4- 7	- 0-4-)
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altimore,	permit. Pages Department of Important: If ii any Injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address				
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2			23a. Part1. Enter the disease, or complications that caused the death. Do no					Approximate
	Physician	(shock, or head faifure. List only one cause on each line.	,				Interval Between Onset and Death
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o.	0 0 0	Physician/Me	1 Tes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	5 Other (specify)				
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Vital	ification, pa	Ö	25. Was case referred to medical		26. Place of Death	1 Yes 2 1	No 1 ☐ Yes	2 No
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	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) The discrete state of the basis of examination and one and manner state.	death occurred at the time or investigation, in my opi	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
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			30. Name and address of person who completed cause of death (Item 23a) (T		2 (8	1/0	-1100	
śН	-24+1		Robert Guedenet 21 Wyand	Dr. Kred	luxuille	MD 217	56	
100	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ , , ,	1			
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State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:06 p^M David D. Saxton 01 25 2006 /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Union Hospital Elkton 8. Date of Birth (Month, Day, Ye 7/27/18 Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 ☐M 2 ☐ F 87 Yrs. Director 222-03-1483 MD Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 63 Maple Dr. 19713 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Security attendant DE State Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David A. Saxton Lula Mae Dryden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Trough Saxton (wife) 63 Maple Dr. Newark, DE 19713 of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🚾 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 1/27/06 Wilmington, DE 22. Name and Address of Facility 21. Signature of Funeral Service-Licensee elolas reollelle McCrery Funeral Homes, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the disease, or complications that caused the death. Do not enter the disease, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Williams Bastro Intestinal Bleeding Immediate Cause (Final Priysician disease or condition resulting in death) /Medical **Examiner** Therosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its and assets. Examiner that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician ician/Medical the t IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached Physi 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Monknown Varkinsons disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tyes this 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tite of certifier 00023322elider 5 MD 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Suite 3B, Eliter MD 21921 31. Date filed (Month, Day) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** SUTTON **EUNICE** R. Jan 2006 2:00 PM /Medical 4a. Facility Name (If not institution, give street and number)
Genesis HealthCare - Th 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Pines Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year DEC.16, 1 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex **Funeral** Days 1 ☐ M 2 🕱 F TENNESSEE 227-12-5306 Director 90 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No STEVENSVILLE **QUEEN ANNES** Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code ō 21666 600 ZAIDEE LANE "naturel", or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. is marked other then College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 8 -0-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h EDWARD INGLE MAMMIE EVELYN BUTLER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 ZAIDEE LANE, STEVENSVILLE, MD 21666 CLAYTON B. SUTTON/ HUSBAND item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition t. Pages rtment of h 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY JAN.9,2006 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) permit.
Departimonts any injury 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death congestive hourt Immediate Cause (Final failure Pnysician disease or condition resulting in death) /Medical Due to (or as sonsequence of): Examiner (Komile if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or - s a consequence of): Examine 1405deroza use as the burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the burial Box 68760. certificate be Physician/Medicai d IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 2 No Hospitel or Attending Physicien: 24 hours after death. Funerel Director; After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ursing Home 5 Residence 6 Other (Specify) No. 3 DOA 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1.X.Natural 5 Pending investigation М 1 ☐ Yes 2 □ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the the 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

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Name and address of person who completed ca

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of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** \mathbf{A}^{M} JANUARY 8, 2006 KATHERINE LUISE STATZ 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** QUEEN ANNE'S STEVENSVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

SEPT. 20, 1913 108 SOMERSET ROAD STEVENSVILLE 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 💢 F Director 92 GERMANY 056-07-0474 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo QUEEN ANNE'S STEVENSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 108 SOMERSET ROAD 21666 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No WHITE Specify: Specify: 3 X Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 27 Is marked other r treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe 2 1 and 2 should KARL AUGUST KULLER HELENE GERTRUDE HOLLGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Item 27 Is y or other tree ROBERT J. STATZ/SON 115 BEVERLY DRIVE, KENNETH SQUARE, PA 19348 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Pages CHESAPEAKE CREMATION CENTER, LLC. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2006 STEVENSVILLE, MD 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lime. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed physiclen and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Por Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificete 1 ☐ Yes 2 ☑ No 1 🗌 Yes 2 No of Vital director. Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 Z No 9 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After Division or Attending 5 Pending Natural Injury efter death.

Director: Af
d in by the ful 1 Tyes 2 □ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funerel C completely filled Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Dale signed (Month, Day, Year) 29b. Signature and little of certifie 29c. License number 30. Name an addr ss of person who completed cause of death (Item 23a) (Type, Print) tchie Hwy, Arnold Md-21012 Antonia ucis 1509

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** \mathbf{A}^M JANUARY 13, 2006 ANDREW CHARLES SCHIPUL 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 836 WRIGHTS NECK ROAD CENTREVILLE OUEEN ANNE'S If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 51 Yrs. MAY 15, 1954 NJ 179-46-0289 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Madical Examinar mant be notified at 1 ☐ Yes 2 X No Director MD OUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 836 WRIGHTS NECK ROAD 21617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** TEACHER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event once. ANDREW C. SCHIPUL THORA EDNA AARON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON L. SCHIPUL/ WIFE 836 WRIGHTS NECK ROAD, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 1-16-2006 CENTREVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. mal Untille 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Ent # the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one as so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amy whyshic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) 4 Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 🗆 No Yes 2 No or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After 1 Alatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours To the Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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[Insertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle dicertifier 39 93 6

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Dr. ve closh, Mil 2/6/9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

are

32. Regierar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Tavlor Shirley Y. January 19, 2006 9:47 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital 8. Date of Birth
July 9, 1949 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 2QF Washington, DC 56 Director 578-68-6586 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Prince Georges MD Upper Marlboro Director Y□Yes 2□No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 12919 Trumbull Drive 20772 United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Exampra 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 years Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice M. Thompkins Nathaniel R. Wynn ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12919 Trumbull Dr. Upper Marlboro, MD 20722 Bobby R. Taylor Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 1/28/06 Maryland Harmony Memorial Park Landover, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Austin Royster" Funeral Home 14th St. NW Washington. 23a. Part1. Enter the disease, or complications that caused the death. shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): anding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery etter for L 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 (autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 100 1 2 inpatient 2 ER/Outpatient 3 DOA ctor: After this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending investigation Injury death. 1 Tes 2 No within 24 hours after deat To the Funerel Director; 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier 29b. Signature ap title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 of death (Item 23a) (Type, Print) Arastoo Yazdani M.D. 0 015 Day. Registrar's Signature 31. Date filed (Month. State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Martha E11a Thornton January 25 06 11:11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner A MD
If Under 24 Hrs. 8. Date of Birth
Hours Min. Ju(Month. 22, 1923 CIVISTA MEDICAL CENTER PLATA CHARLES 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year Social Security Number Funeral Days Maryland 82 577-26-1995 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Neulcal Evantinar must be notified at 1 Yes 2 No La Plata Director MD Charles | 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 12822 Crescent Run Street 20646 USA by Funerai 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itar 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1□Yes X No White #876 E. 19821215-0036 Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Marketing Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Schuler Jane Cornwall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is rr any injury or other traurr once. 12822 Crescent Run St. La Plata,MD 20646 Sadie Jackson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

★D Burial 2 ☐ Cremation 3 ☐ Removal from State completely, crematory or other place)

. Peters Cemetery 1/30/06 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, PA. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list nondtrons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown HEART CONGESTIVE Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 **3**00 To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26 Place of Death Check onlone Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 T Homicide To the Funaral Dir. 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AHENDING au D -44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL MEllow IT WALDORF MM J PATEL ASHVINKUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - For State Registrar	State of	Marylan		artment rtificate			and M	_	giene Reg. No. () (16	03765
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Example fruits the Inditial at anote.	1	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	er or Rura.	Route Numb	er, City or Town,	State, Z	Zip Code)
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Funeral Director		5. Social Security Number 6. Se 579–58–5130	7. Ag	ge (In yrs. last birti	hday) (rs.	If Und Months	or 1 Year Days	If Under 24 H	n (/	ate of Birth Month, Day, Y	(ear) , 192	9. Birthp Coun Sp	lace (State or Fore try) pain		
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Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other traumatte event, the Medical Examination and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 540idowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:	Ever in U.S.		Was Dec f Yes, sp		spanic Origin? n, Mexican, Pue Specify:	(Specify) erto Ricar	Yes or No- n, etc.)	14. Ra	ace - Americ lack, White, c	etc.		
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h and M 7 is mar traumat		19a. Informant's Name/Relationship (T)									Number, City or Town, State, Zip Code)				
nt: If item 2	-	Maria A. Villa/ D 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ne Drive, Silver Spring, MD 20906 Date 20c. Location - City or Town, State 27 Date 2006 Washington, DC					wn, State							
Depertm Importe any inju once.		21. Signature of Funeral Service Licens	Home Inc Lver Spring, MD 2090												
	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	ry Embol a consequence of	f):								Immediate		
ettending for use e	rnysician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic Other (s	oregnancy specify)					Date of delive Month	ry Day Year		
e d	<u>~</u>	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the ur	nderlying	cause giver	n in Part I.	. 2				e cause of death? ably 4 DUnkno		
cate hes	Completed									24a. Was an autopsy performe	ed?	were autor prior to con death?	osy findings availa npletion of cause (2 No		
5 a 15	Ceruncanon: 10 De	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 ⊠ Inpatie 28a. Date of Inju (Month, Da	ry 28b. Ti y Year) In	me of tury	м	OA Other 28c. Injury Work? 1 □ Y	4 Nulsing	Home 28d. (5 Residen	injury occu	urred			
24 hours after deat Funeral Director: letely filled in by the		4 Homicide determined	building, et	ury - At home, fan c. (Specify)						City or Town,	State)		l Route Number,		
S E Q 1	medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	ner: On the basis o and manner st	f examination and	death Vor inv	estigatio	n, in my opi	nion, death oc	ce, and d	the time, date	and place	e, and due to	the cause(s)		
7		· Asc	2				D5977					y 24,			
		30. Name and address of person who od Harris Solomon, M		leath (Item 23a) (1 00 Conne			Avenu	ıe, Ken	sing	ton, M	D 208	95			
State Registra	-	31. Date filed (Month, Day, Year) JAN 2 6 20		ar's Signature	Sou	de									

		1 - For Stata Registrar			d / Depa		Health an		al Hygi	ene 0 0 6	03769
Physici	an	1. Decedent's Name (First, Middle,	Last)				, Dodin	M	ate of Death	Day Year	3. Time of Death
/Medic Examir		ERICH 4a. Facility Name (If not institution, g	nive street and num	nber)	W1	NTER 4b. City. Town	n, or Location of D		UARY .	23, 2006 4c. County of Death	8:15 A M
Exami	iei	17600 BOWIE MILI		,			ROCKVILLE			,	GOMERY
Funeral			. Sex	7. Age (In yrs.		If Under 1 Ye Months Dar	ar If Under 24 I	ate of Birth Month, Day,		pplace (State or Foreign intry)	
Director		NONE Usual Residence of Decedent	1⊠M 2□F	96	Yrs.			SEP	T 21,	1909 CZEC	HÓSLOVAKIA
/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
Mary filled	ţoţ	MARYLAND MO	NTGOMERY			RC	CKVILLE				1X Yes 2 □ No
or 28	Jire	10e. Street and Number				10f. Zip Cod			10	g. Citizen of What Cou	untry?
ath w	rail	17600 BOWIE MILI					20855			EQUADOR	
ier de Items	nue	11. Marital Status 1 ☐ Never Married 21 Married	12. Was Dece Armed For 1 ☐ Yes	ces?	S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? Suban, Mexican, Pi	? (Specify Y uerto Rican	es or No- , etc.)	14. Race - Amer Black, White	
urs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	8		1 □ Yes 2 🔯 1	No Specify:			Specify: WHI	TE
72 ho	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Oc	cupation ne during most of	Lunckina	16	3b. Kind of Business/I	ndustry
ithin 1	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. i	DO NOT use re	tired)	WOIKING			
lled w Hygier her th	S	17. Father's Name (First, Middle, La	<u>4</u>		EXE	ECUTIVE	19 Mothodo	Nama /Fire	t Middle M	TEXT	ILE
d be fi	Be C	HESKEL WINTER	51/				11 UNKNO				
at y fail to Z i Z i 2-0000 should be filled within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "neturel", or items 23e or 28e-1 show martic event, the Medical Examiner must be notified at	ĭ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Str				City or Town, State, Z	ip Code)
nd 2 alth ar alth ar 27 is		ANTIONETTE C. ME		GHTER)		_				LLE, MARYL	
of He a		20a. Method of Disposition 1 Burial 2 Cremation 3	DRamausi fram 6		lace of Dispo	sition (Name of natory or other	place)	Date	20	oc. Location - City or 1	own, State
Pag ment ent: t		'4 □Donation 5 □Other (Spe		JUD	EAN ME	EMORIAL	GAR. 01/	/24/20	06 01	LNEY, MARY	LAND
patitified by India yiality 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "neturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Savins Lic	ION, INC.								
40569		23a. Part1. Enter the disease, or co	LLE, MARYL	AND 20852 Approximate							
Pnysician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. <u>CARD</u>	IOPULMO	NARY A		aying, sasir as sair	10100 07 700	onatory arros	4,	Interval Between Onset and Death
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e be ex	icai E				301130 3.7.						
g physas the			C								
th cert endin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnanth 2 Testa		Ectopic pregna	Incv			23d. Date of deliv	,
e deal	sicis	in the past 12 months?		ant at time of d		Other (specify				Month	Day Year
hat the		9 ☐ Unknown Part II. Other significant conditions	s contributing to de	ath but not res	ulting in the u	nderhing cause	green in Part I		3a Did toba	cco use contribute to	the cause of death?
The Coldas, F.C. box 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by	Tarris office organization	o contributing to do	atti but not 193	unting in the u	noonying cause	giver in Farts.				bably 4 XUnknown
w requ	lete				-			_	24a. Was an	24h Were aut	opsy findings available
he lay	Completed	-					·	_	autopsy perform	prior to c death?	ompletion of cause of
ding Physicien: The lav h. After this certificate has funeral director, page 2	0	25. Was case referred to medical					26. Place of		Yes 2		2 No
Physicien: rthis certifica	To B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 🗆 lr	npatient 2	ER/Outpatier	nt 3 DOA				ce 6 □Other (Spec	ity)
ding Phy h. After this funeral o		27. Manner of Death 1 Natural 5 □ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	28c. i	njury at Work?			injury occurred	
Witendii death. ctor: A y the fu	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t he				Yes 2 □ No				
or At after of Direction by	Certification:	4 Homicide determin	ad 286. Place	of Injury - At ho ig, etc. (Specif	ome, farm, str v)	eet, factory, offi	ce		ocation (Stre	et and Number or Ru State)	ral Route Number,
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1X Certifying	Physician: To the	best of my kno	wledge, deat	h occurred at the	e time, date and p	place, and di	ue to the cau	ise(s) and manner as	stated.
n 24 h	edicai	(Check only 2 Medical Ex	aminer: On the ba	isis of examina	tion and/or in	vestigation, in π	ny opinion, death o	occurred at	the time, dat	e and place, and due	to the cause(s)
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	Ž	29b. Signature and title of certifie	11				ense number			d. Date signed (Month	
6		7/17///					45869 		J.	ANUARY 24,	2006
4		30. Name and address of person with					DITTE C		MADIT	AND OCCUP	
Sta	ato	31. Date filed (Month, Day, Year)	1				DKIVE, OI	LNEY,	MARY L	AND 20832	
Regist		JAN 26	2006	egistrar's Signa	K A	and I					

AEM 06-00679 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. UU6 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JEFFERY ALAN WROTEN 2006 9:45 A January /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye 11/10/1961 Birthplace (State or Foreign Country)
 WEST VIRGINIA 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□XM 2□ F 44 232-98-6009 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other then "netural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at treumatic event, the Medical Examinar must be notified at MARTINSBURG Yas 2 No BERKELEY Director WV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 N. COLLEGE STREET 25401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? VAYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X2X☐ No Specify: Specify: WHITE δ 3 ☐ Widowed 4 💢 Xvorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ROXBURY CORRECTIONAL Elementary/Secondary (0-12) College (1-4or 5+) CORRECTIONAL OFFICER INSTITUTE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HELEN SINNETT JOHN R. WROTEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If Item 27 Ien eny Injury or other tree 5339 COURTFIELD DRIVE, INDIAN TRAIL, NC 28079 KAILYN W. PETTY/SISTER 20b. Place of Disposition (Name of cometery, crematory or other place)
SUNSET MEMORIAL GARDENS 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XX urial 2 Cremation 3 Removal from State PARKERSBURG, WV Feb 2,2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BROWN FUNERAL HOWE, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Chaeles M - Deoren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshot would head and neke **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the ettending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificete has been sign rector, pege 2 should be 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of de 11.? 1 Yes 2□ No 2 🗆 No or Attending Physicien: After this certification Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: XXX npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXXes 2 □ No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 XYes 2 □ No investigation 26/05 2 Accident 1526 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Washigher lovety hospital (text, H Hospital within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 29, 2006 cause of death (Item 23a) (Type, Print)

State Registrar

SH-10+1

DHMH 17 Rev 1/2001

31. Date filed (Month) Day

32. Registrar's Signature

111 Penn Street Baltimore, Maryland 21201

			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	-	giene Reg. No.	16 (3771
¥			Decedent's Name (First, Middle, Last)	2. Date of De	ath		3. Time of Death
	Physicia /Medic		Robert Leonard Walker	Month Januar	y 25,	Year 2006	1:10 P ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. Coun	ty of Death	
			Manor Care Nursing Home Bethesda			gomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthpl	lace (State or Foreign try)
	Director		206-01-2565 92 Yrs. 92 Yrs.	Sept 7,	1913	New Y	ork
	land low		10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
	a-f st	ctor	Maryland Montgomery Bethesda				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Coun	try?
	ath w		6530 Democracy Blvd. 20817		USA		
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No Rican, etc.)	- 14. Ra	ace - Americ lack, White, e	
5	rs aft	by F	1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates: 1941-46		Spec	ify: Whi	te
9500-61212	be filed within 72 hours after death with the Marylan Ital Hyglien. Id other than "naturel", or Items 23a or 28a-f show event, the Medical Estimate count to colling a	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of		
2 2	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of workil life. DO NOT use retired)	ng			
7	ad wil	Con	4 Logistician		Federa		rnment
	be file tal H) d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			ame)	
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exam. In finite Leafilled at	٩	Myron Reed Walker Vitaline			T	- 1
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Type, Print) Myron Dow Walker/son 19b. Mailing Address (Street and Number or Rura 4107 Maryland Ave. Beth				Code)
<u>က်</u>	1 and Healt Iem 2			ary 27	20c. Location		wn, State
٥	ages ant of it; If it y or c		I Dunai 2 KUCiemation 3 Unemovarioni State		Reltev	ille. 1	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation				
ñ	permi Depar Impo any ir		Horay & Helita Mol251 Beverly L. Heckrotte	a Servi	ce P.C Clarks). Box sville	784 MD 21029
Г			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition Pneumonia				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. Denontia Due to (or as a consequence of):				
	ed isit	line	cause. Enter Underlying				
	be executed ician and burial-transil	Examine	Cause (Decade or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
9/60	icate be executed physician and s the burial-transit	dical	d				
200	the death certificate y the attending phys tched for use as the	Φ			7		
ŏ	eath certific attending pi	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		I	ate of delive	,
n.	o deat	Physician/M	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
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ŝ	The law requires that tte has been signed b age 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 🗆 1		3 ☐ Proba	
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Vital	(0 14	e Co	25. Was case referred to medical 26. Place of Death	1 Yes	2X No	1 🗆 Yes	2 No
	ysician: is certific director,	OB	examiner? 1 Yes 2 No			ther (Specify	')
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<u>o</u>	ttending P death. stor: After t	atlo	2 Accident investigation M 1 Yes 2 No				
DIVISION	r Atta ter de irecto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox		nber or Rura	l Route Number,
\Box	pital or ours afte eral Dii filled in	O					
		edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a constant of examination and/or investigation, in my opinion, death occurred and manner stated.				
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie 22b. License number		29d. Date sigr	ned (Month, I	Day, Year)
	⊬ ≯ ⊢ ŏ		Н51280		January	7 26.	2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,,	
			Anushiravan Dadgar, D.O. 9715 Medical Center Dr. Suite	201 Ro	ckville	e, MD	20850
	Sta		31. Date filed (Month, Pay, Year), 2006 32. Registrar's Signature				
	Registr	ar	Will Will and The State of the				

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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FEB

111 PENN STREET, BALTIMORE, MARYLAND 21201

miD

32. Registra Signature

DHMH 17 Rev 1/2001

Registrar

JAN 26

2006

Charles H. Baltimore, Maryland 21215-0036 Apura

Diage	Type or Print in Black Indelible Ink. Ensure A	All Copies Are Legible	
Picase			
trar	State of Maryland / Department of Health and I Certificate of Death	vientai Hygiene	0
nt's Name (First, Middle, L		2. Date of Death	

		1 - For State Registrar			C	ertificate of l	Death		Reg. No.	0	13/14		
		1. Decedent's Name (First, Mid	dle, Last)		2. Date of Death 3. Time of								
hysici/Medic		Charles H. A	\burn					Feb.4,	2006	1041	1:58p.m		
xamir		4a. Facility Name (If not institute				4b. City, Town, or	Location of Death		4c. Count	y of Death			
	2	Civista Medi				LaPlata			Char				
ineral rector		5. Social Security Number 219-22-4526 Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In	77 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/9/19)	y, Year)		place (State or Fore ntry) yland		
Mo W		10a. State 10b. Coun	ty	10	c. City, Town o	r Location					10d. Inside City Lim		
r 28a-f show rctiffed at	to	MD Char	100	1	Valdorf				1 Tes 2				
or 28a e notii	Director	10e. Street and Number	103	1 1/1	vargori	10f. Zip Code			10g. Citizen of What Country?				
238 o		4150 Doctors	Samuel Ro	ad		20601			USA				
Therm	Funeral	11. Marital Status 1 Never Married 2 1	Armed	ecedent Ever Forces? s 2 No	r in U.S.	13. Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No Rican, etc.)	Bla	ce - Americack, White,			
E E	d by	3 Widowed 4 Divorce	ed If Yes, t	Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Speci	Specify: WIII LE			
natu deal	Completed	15. Decede (Specify only high	ent's Education	d)	16a. Do	ecedent's Usual Occupa Give kind of work done of fe. DO NOT use retired	ation furing most of work	ing	16b. Kind of E	Business/In	dustry		
Item 27 is marked other then " other traumatic event, the Ma	ldu	Elementary/Secondary (0-12)		(1-4or 5+)					Como	+ 0.0			
event, the M		12 17. Father's Name (First, Middle	a (got)		Leme	etery Opera		o /First Middle	Ceme				
0 0	Be						18. Mother's Name (First, Middle, Maiden Sumame) Catherine Weber						
natic	10	Charles H. Abu			10h M	Iniling Address (Street				State 7in	Codel		
traur	19a. Informant's Name/Relationship (Type, Print) Helen V. Aburn/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow 4150 Doctors Samuel Road										0 0000		
any injury or other traisons.		20a. Method of Disposition	1, opouse	2	20b. Place of D	sposition (Name of	20601	Date	20c. Location	- City or To	own, State		
000		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of III) 20601 20c. Location - Cit cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of III) 20601 20c. Location - Cit cemetery, crematory or other place) 278/2006 Glen Burn											
injur.		21. Signature Funeral Service	~ ~	10	aren na	22. Name and Addres	. =						
any		1 2	X. 1	31	Stallings Funeral Home, P.A. d. Pasadena, MD 21122								
T-A		23a. Part1. Enter the disease, shock, or heart failule. Li	or complications tha	t caused the	death. Do not	enter the mode of dying	JLCLIII KU. g, such as cardiac	or respiratory ar	nd , MD rest,	21122	Approximate		
		shock, or heart failule. Li Immediate Cause (Final	st only one cause or	each line.		6. 1	,				Interval Between Onset and Death		
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rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):											
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29 (2)	Medical	is sevin e	_										
for us	Physician/	in the past 12 months? Compared to the past 12 months Compare									e of delivery hth Day Year		
should be detached	y Ph	Part II. Other significant condi	tions contributing to	death but no	ot resulting in th	e underlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?		
ld be	d by							1 🗆 Y	es 2 No	3 ☐ Prob	ably 4 Unkno		
irector, page 2 shot	Completed							24a. Was autop		Were auto prior to con death?	psy findings availa mpletion of cause		
r, pa		25 11	-1	·				1 Tes	2 No	1 🗆 Yes	2 No		
rector	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient	2 ☐ ER/Outpa	tions 30 DOA Othe	26. Place of Death			(0			
aral dii		27. Manner of Death		e of Injury anth, Day Yea		e of 28c. Injury	" 4 □ Nursing Ho at	28d. Describe h			у)		
funer	tlor	1 □Natural 5 □ Pend 2 □ Accident inves	tiontion A	G172 175			? 'es 2 (% No	Hung	ing				
by the	iflea	3 Suicide 6 ☐ Coul	minod 28e. la	ce of Injury -	At home, farm,	street, factory, office	form	28f. Location (S	street an um.	ber or Rura	l Route Number,		
od in by the f	Certification:	4 ☐ Homicide deter	Dul	ding, etc. (S)	DECITY)	uel mudo	1 RD	City or Tow		uelu	modd Rs		
completely filled in by the	edical (ing Physician: To t	ne best of my	y knowledge, d	eath occurred at the tim r investigation, in my op	e, date and place,	and due to the	cause(s) and m	anner as si	tated.		
dwo	Me	29b. Signature and title of certif	ier			29c. License	number		29d. Date signe	ed (Month,	Day, Year)		
- 0		ijalina	W. La	gour	·	Do0:	5088	3	2/4,	1200	6		
		30. Name and address of perso	n who completed ca	use of death	(Item 23a) (Tvi								
1.			Protoc Ga				-	7.61	6				
1			VESUP	pl		pe, Print)	MI	2000	O				

Registrar DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760,

			State of Maryland / Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department	lental Hygier	ne 006	03775
	Physici		1. Decedent's Name (First, Middle, Last) Richard Andrew Amos	7 5	Day Year	3. Time of Death
*	/Medic Examin Funeral Director		4e. Fecility Name (If not institution, give street and number) Cood Samavitan Hospital Saltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birth	N/A Mone Ct place (State or Foreign ntry) LAMANO
	ryland thow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
•	in 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow ledical Examinar must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10f. Zip Code 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 1 Was Decedent G Hispanic Origin? (Specific Specific Cuban, Mexican, Puerto		Citizen of What Cou USA 14. Race - Amer Black, White	intry?
2-003b	72 hours atter "naturel", or Ite	leted by	3 Widowed 4 Divorced Year or Dates: WWT 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of works) (If Yes, Give Year or Dates: WWT 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of works)	ng 16b	Specify: ())	hite industry
717.0	filed withi Hygiene. other ther	e Completed	Elementary/Secondary (0-12) College (1-40/5+) Superintende	(First, Middle, Maid	Iranspa den Sumame)	ortation
arylar	should be and Mental Is marked of aumatic eve	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr ss (Street and Number or Rura	Deth A	na B ty or Town, State, Zi	rust p Code)
ore, ma	os 1 and 3 of Health item 27		20a. Method of Disposition Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery) 20b. Plac	e. far	Location - City or T	2234 own, State
Baitimo	permit. Page Department of important: If sny injury or once.		21. Signature of Funeral Service Licepsee 22. Name and Addre of Facility 23. Signature of Funeral Service Licepsee 22. Name and Addre of Facility 23. Signature of Funeral Service Licepsee	celul Alki	ratives f	runeral &
	Physician		23a. Part 1. Enter the disease or complications that a used the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Condition of the	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	Ĺ	resulting in death) Due to (or is a consequence of): Sequentially list conditions, b.			
3/pn, /	ate be executed hysician and the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Lace (Diesace of hijus) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):			
O. Box 68	ath certific ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of dein Month	very Day Year
cords, P	luires that the de n signed by the a ild be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Redul Cyana hele Meumonin	23e. Did tobacc	co use contribute to	the cause of death?
He He	The ate h page	Completed	Multiple Myslema	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
VIIai	sician: certific lirector,	o Be (examiner?	n (Check only one) me 5 - Residence	6 DOther (Spec	(6,1)
sion of	<u>+ = =</u>	-	27. Manner of Death 1 Natural 5 Pending (Month, Day Yeer) 2 Accident investigation 28a. Date of Injury (28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day Yeer) M 28b. Time of Injury at Work? 1 Yes 2 No	28d. Describe how in		
DIVISION	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or within 24 hours after the Funeral Dirticompletely filled in	edical	29a. Certifier (Check only one) 1			
	To the Within To the comp	Σ	29b. Signature and title of certifier 29c. License number		Date signed (Month	
	10+1		30. Name and address of erson who leted cause of death (Item 23a) (T pe. Prin) Davis M. Hahn 560 (bach Raven Blo	1000000	1/07/0	11
	Sta	te	Davis M. Hahn 5601 both Raven Blog 31. Date filed (Month, Day, Year) 32. Registrar's Signature	16 /Su	lto. M	W 2/239
24.0	Registr		FFB 1 0 2006 Paris & Conti			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 16:23 PM BILLINGTON FEBRUARY KOSEMARY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner THE JOHNS HOPKINS BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax Days **Funeral** 1 M 2 XF 54 Yrs May29,1951 217-52-9036 Director MAryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be nutified at Baltimore 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21224 933 Elton Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of MAryland Claim Processor 4yrs 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fite Oppartment of Health and Mental by Important: If Item 27 is marked oth any injury or other traumatic event 900g: Be MAry E. Tankersley Phillip Duffy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 520 Old Riverside Road BrooklynPark MD / son James West 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □ Burial 2 🗷 Cremation 3 □ Removal from State BayviewCrematory Baltimore MD 2/11/06 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or completations that caused the death for not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only the cause on each line. Baltimore MD 21221 Interval Between Onset and Death Immediate Cause (Final 4 MENTHS MYELOCYTIC LEUKEMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the l IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month ō 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. · by 3 ☐ Probably 4 ☐Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital 2 ER/Outpatient 1 ☐ Yes 2 No Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 7, 2006 Medical Doctor Res - 000 LIPSON. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21237 The Johns 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	aryland / Dep	artment of H	ealth and f		giene	03777
		i, At	1. Decedent's Name (First, Middle, I	Last)				2. Date of De	Day Year	3. Time of Death
	Physic /Med		JEAN ROSLYN	BRUSO				tebruo	ury 7, 2001	
	Exam	ner	4a. Facility Name (If not institution, g			4b. City, Town, or		1	4c. County of Dea	
		- 14	Upper Chesapea 5. Social Security Number 6		Center ge (In yrs. last birthday)	Bel A:	L Y If Under 24 Hrs.	8. Date of Bir	Harfor	thplace (State or Foreign ountry)
	Funera Director		019-20-6667	1 □ M 2 🔀 F	78 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Mar. 23	y, Year) C 3, 1927 Mass	sachusetts
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	15-0036 72 hours after death with the Maryland "netural", or iteme 23e or 28e-f show colcel Examinar must be natilised at	ō		x+ 0x	Leiceste					1 ☐ Yes 2 → No
	r 28a	Director	MA Worces 10e. Street and Number	iter	Leicesce	10f. Zip Code			10g. Citizen of What C	ountry?
	th with 23a o		457 Pleasant S	št.		015	24		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Am Black, Whi	
	36 s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
	21215-0036 d within 72 hours after giene. or than "netural", or ite		15. Decedent's	Education	16a. Dece	edent's Usual Occup	ation		16b. Kind of Business	
	within 73 ene.	Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or	5+) (Give	kind of work done of DO NOT use retired	furing most of wor)	King		
	21 ed will	Cou	12		Wai	tress	40.14-4-1-1-1	- /5' 44'	Restaura	nt
2	and libe fill half H	Be	17. Father's Name (First, Middle, La Henry E. Under					A. Lenc	, Maiden Sumame)	
Jeun	Maryland 2121 at 2 should be filed within the and Mental Hygiene. The marked other than "traumatic event, the Mack	10	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street			er, City or Town, State,	Zip Code)
4	Ma nd 2 s lith ar 27 is r trau		Keith A. Bruso		908	Hamburg I	Drive. Al	oinadon.	MD 21009	
6)	other		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place		Date	20c. Location - City of	Town, State
15(Page Page nent c		1 □Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		1	me Cemete		1-06	Worcester	, MA
BWNSO	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic event, that Mandel.		21. Signature of Funeral Service Lie	censee	1	Name and Address McComas Fi	ineral Ho	ome, P.A	٨.	
8	m goesa		Maile 2	om ications that cause					ngdon, Mary	land 21009 Approximate
			23a. Part1. Enter the dishase, or shock, or heart failure. List or Immediate Cause (Final	nly one cause on each I	line.	0-11				Interval Between Op et and Death
	Physician /Medica		disease or condition resulting in death)	a	s a consequence of):	411 1	ung	Cance	<i>r</i>	6 WIDIAS
-	Examine	_	1		s a consequence or).		/			
E		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequence of):					
0	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dura to /or s						
1	760, te be executed ysicien and he burial-transit	calEx	Tosuling in doubly East	Due to (or as	s a consequence of):					
3/10	5 × 6		<u>.</u>	d						
10	Box (sath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	alivery
	O. B.	Cla	in the past 12 months?			□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
je	P.O.	hys	9 Unknown						6100 -	
2/	S the digner of	5	Part II. Other significant condition	s contributing to death I	but not resulting in the	underlying cause giv	en in Part I.		tobacco use contribute gres 2 □ No 3 □ F	Probably 4 Unknown
1	Vital Record iclan: The law requir certificate has been si	Completed								
Q	Rec	Id m						24a. Was auto perf	opsy prior to ormed? death?	
	Vital Recipion of the same of	ပိ	25. Was case referred to medical				26 Place of De	1 ☐ Yes	7	s 2 No
4	of Vita Physician: rihis certific	0 8	examiner?	Hospital: 1 ☐ Inpati	ient 2 X ER/Outpatie	ent 3 DOA Oth	00		idence 6 □Other (Sp	ecily)
15	on of ding Phys. After this if funeral dir	n: T	27. Manner of Death	28a. Date of Inj (Month, Da	ury ay Year) 28b. Time Injury	of 28c. Injur			how injury occurred	
8	Vision Attending or death. ector: After	catio	Natural 5 ☐ Pending Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion		M 10	Yes 2 □ No			
29	Division of to Attending Phy after death. Director: After this in by the funeral of	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place of It	njury - At home, farm, s etc. (Specify)	treet, factory, office			(Street and Number or F own, State)	Rural Route Number,
# 299513	Hospitel or Hospitel or 24 hours afte Funerel Dir stely filled in		29a. Certifier Certifying	Physician: To the bes	t of my knowledge, dea	ith occurred at the tir	ne, date and place	and due to the	cause(s) and manner a	as stated.
#	Division of Vital Revision of Vital Revision of Vital Revision of the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	edical	(Check only 2 Medical E)	xaminer: On the basis and manner s	of examination and/or i stated.	nvestigation, in my o	pinion, death occi	urred at the time	cause(s) and manner a , date and place, and du	ue to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	44.7		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
			NIF	MD		PS	4652	-	Honyary	8 2006
	6		30. Name and address of person w	ho completed cause of	death (Item 23a) (Type	e, Print)	D. 1	1.	Many Is	8,2006
	The second second		31. Date filed (Month, Day, Year)	SW///	trar's Signature	HVINA	01/	1715	und Labin	21011
X	Regis	tate trar	FEB 1 0 2	16.1	, St. Am	المستالين				

			For State Registrar	State of M	aryland	•	artment tificate			and M	F	Reg. No.	96	03778	_
ı	Physicia		1. Decedent's Name (First, Middle, L Everett Bradsha							E E	2. Date of Dea Month	Day	Year	3. Time of Death	
	/Medic	al	Everett Bradsha 4a. Facility Name (If not institution, gr		1		4b. City, T	Town, or	Location o		BRUARY		⊇ØØE ty of Death		_
	Examin	er	Saint Joseph	Medical	Cent	er				owso	n			imore	
	Funeral			Sex 7. Ag	ge (In yrs. Ia	ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da)	h y, Year)	Cor	place (State or Foreign intry)	
	Director		212-07-4287 Usual Residence of Decedent	M ZUF	0,5	Yrs.					02/04	(/1917	MD		_
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	_
	Many	ţċ	MD Baltim	ore	Lut	hervi	lle Ti	imon	ium					1 ☐ Yes 2 ☐ No	
	or 28	Oire	10e. Street and Number				10f. Zip					10g. Citizen o			
	within 72 hours atter death with the Maryland ene. then "natural", or Iteme 23a or 28e-f ehow the Medical Examinar moral be incilliad at	Funeral Director	208 Rothwell Dri				210					United			_
	ter de Item	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces	?	5. 13.	Was Decedo 1 Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)	- 14. H	ace - Amer ack, White	ican Indian, , etc.	
21215-0036	urs at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	****		1 ☐ Yes 2	No.	Specify:			Spec	ity: Whi	te	
2	72 ho	Completed	15. Decedent's I (Specify only highest g			16a. Decec	dent's Usua kind of wor	l Occupa	ition Jurina mosi	t of worki	n <i>a</i>	16b. Kind of			_
2	vithin ne. hen	du d	Elementary/Secondary (0-12)	College (1-4or	5+)	Presi	DO NOT us	e retired))			Nation	ıaı E	ngineering	
, D	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Las	2		r resi	Lacire		18. Mothe	r's Name	(First, Middle,	Maiden Suma	ime)		_
au	id be ental ked o	To Be	William Everett						Ella	May	Gillett	.e	·		
Maryland	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show eny figury or other traumatic event, it a Medical Examinar must be inclined at announce.	-	19a. Informant's Name/Relationship	(Type, Print)		1	-				Il Route Numbe	-			_
Σ	of Health ar item 27 le		Bradshaw/Wife						Drive	Lut	hervil		, MD 21093		
Baltimore,	Jes 1 I of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	☐Removal from State	СӨ	ace of Dispo metery, cren	natory`or ot	her place			Feb 10	20c. Location			
ŧ	t. Pertrent:		4 Donation 5 Other (Spec	ify)	Che	esapea							ille,	Maryland	_
Ba Ba	Depermine Depermine Properties of the Ponce Properties		21. Signature of Funeral Service Lic	utter M	0144	3 8	3717 G	reen	Pastu	res l		altimor	e, Ma	ryland 21286	<u>: -</u>
			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	nplications that ceuse y one cause on each l	d the death ine.	. Do not ent	er the mode	of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a ASPIRA			IMONI	A							
	/Medical Examiner		1	Due to (or as	a consequ	ence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
>	cuted	mulu	Cause (Disease or injury that initiated events												
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8760,	The law requires that the death certificate be executed tite has been signed by the attending physicien and age 2 should be detached for use as the burial-transit		•	d								· · · · · · · · · · · · · · · · · · ·			
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	To the Hospital within 24 hours e To the Funeral completely filled	edical	(Check only one)	hymician: To the basis miner: On the basis of and manner s	of examinati	ion and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time,	date and place	e, and due	to the cause(s)	
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	13		30. Name and address of person wh	completed cause of	death (Item	23a) (Type,	Print)				,				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Voar **Physician** Month Bennet 8:00PM ose arolyn 03 02 2006 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Healthand Rehab Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year 1-16-1912 Funeral Year) Days 1 □ M 2 X F 112-09-9505 Director Hungar a Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itame 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Montgomer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 Girosvenor ane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Whi Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benczi Unknown leresa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 to ury or other tra Aurora Dr. Kensington, MD 20895 arolyn Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beltsville, MD permit. Page Department of Important: If any injury or once. Shesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ropp Funeral Acremation Services 21. Signature of Funeral Service Licenses 933 Grist Ave. Silver Spring, mD 20910 MU1358 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rne umonia days /Medical Due to (or as a consequence of): Examiner monic obstructive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner for use as the burial-transit The faw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by sign. 1 Yes 2 No 3 Probably 4 Unknown Severe Ostegarthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 Yes 2 No 2 Accident in by the after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after to the Funeral Dil completely filled in Medical 29a. Certifier ix certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D19609 lale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd. Ste 202 Gaithersburg, MD 20878 Raman RiTuli, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

death Christopher Burke 2/9/2006

Physician

Funeral

Director

Item 27 is marked other than "natural", or Itama 23a or 28e-4 ahow other traumatic event, the Madical Examinar must be notified at

and Mental Hygiene.

if Item 27

Physician

/Medical

ō Department of Important: If any injury or once.

the Maryland

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Examiner the burial-transit The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760 for use as the detached sate has been signed by page 2 should be detacl certificate has siul

To the Hospitel or Attending Physician: the funeral director. death. Director: 24 hours a within 2 To the 1

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Philip Militella

Year)

2006

31. Date filed (Month, Day,)

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 1420 hrs™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16 Tack Court Essex Baltimore | If Under 1 Year | Il Under 24 Hrs. | 8. Date of 8 inth (Month, Day, Year) | AUG 3, 197 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Age (In vrs. last birthday) 1 X M 2 ☐ F 30 217-13-5872 MD Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Tack Court 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Retail 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First Middle Last) Be Richard Franklin Burke Eileen Merkle 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula E. Burke - mother 16 Tack Court, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 2/11/2006 Beltsville, MD 21. Signature of Funeral Service License CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GunshoT wound To head 5 minutes Due to (or as a consequence of): Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe haw injury occurred Certification: 1 Natural 5 Pending investigation Selfuflicted GunsHOT wound February 9,2006 1420 P 6 Could not be determined 28I. Location (Street and Number or Rural Route Number, Chart Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

We discuss Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

to completed cause of death (Item 23a) (Type, Print)

Trimble Hill

D18667

CT. Luthau: lle, MD

February 10, 2006

O6-00917
Vivella Burley

1Physician
(Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2/a,2/, per/F, (%52,2/22/00)

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/Medic	al	VIVELLA	BURLES			45 Cit. 7	Court or I			Februa		5, 20 County o	006	18:26	М
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Funeral			Sex 7. Ag	ge (In yrs. last	birthday)	If Under		If Under:		8. Date of Bir	th		9. Birthp	lace (State or	Foreign
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eep .	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decede	ent of His	panic Ori	gin? (Spe	ecify Yes or No Rican, etc.))-		- Americ	can Indian, etc.	
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		30. Name and address of person who		death (Item 23			ı Str	eet.	Bal	timore	. Mar	ry1an	nd 21	1201	
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature				,			,				
Registr	ar	FFR 1 0 200	S Page	And the	Asa	and the same									

NLM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.27, pen/ft. 632.27/06 IT

Amend item#19a, pen/ft. 6333, 372/06 in the standard Mental Hygiene 06-00984 Jonathan Booker 1 - For State Registrer Certificate of Death Reg. No. UU6 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 Halley Booker February Jonathan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Veterans Administrative Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan . 16, 1961 Birthplace (State or Foreign New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 45rs Director 122-50-5324 Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Harford Edgewood Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21040 3461 Albantowne Way Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYes 2 No 1980— If Yes, Give Year or Dates: 2000 1 Never Married 2 Married B1ack Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Fork Lift Operator Rite Aid Stores 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Depertment of Health and Mentel Hy Important: if tem 27 is marked oth eny liury or other traumatic event 2008. Elnora Logan Haven Booker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
263 Palisade Avenue, #2C, Yonkers, New York 10703 19a. Informant's Name/Relationship (Type, Print) Laurie Pettiford Booker - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) Feb.13,2006 Yonkers, New York Oakland Cemetery 22. Name and Address of Facility Brooks Memorial Home, Inc. 21. Signature of Funeral Service Licenses M01113 MUM 275 Warburton Avenue, Yonkers, NY 10701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Acute pancreatitis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No hes autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۵ 1 XYes 2 ☐ No 1 ☐ Kpatient 2 ☐ ER/Outpatient 3□ DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cerff(ie FEB. 8, 2006 OCME 30. Name and address of person of death (ttem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 0 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar FEB 1 0 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 4, George James Barthel 4:45 p м 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glade Valley Nursing Center Walkersville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Oct 3, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
New York **Funeral** 1**⊠**M 2□ F 065-18-3006 82 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location Frederick Oa State 10b. County 10d. Inside City Limits ns 23e or 28a-f show Maryland Frederick Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Whittier Drive 21702 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "naturel", or Items 23 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1943-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify 3 X Widowed 4 ☐ Divorced White 1949 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Volunteer Community Groups 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barthel George Mary Agnes Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Barhel, Son 16606 Spiceberry Ct, Apt B, Hagerstown, MD 21740 other 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department of Importent: if eny injury or once. Mt Olivet Cemetery Feb 9, 2006 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Keeney & Basford Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signatur of Funeral Service Lice see √M00706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBRAL VASCULAR Physician ACCIDENT /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit igned by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bleen si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 1 ☐ Yes 2 ☑ No 1 Tes 2 No To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examination in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0047951 2.6-2006 JM2 Hb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A LAZMI UN SIY TOUL HOUSE AVE FREDERICK MD 7. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FFB 1 0 2006

				State.of Maryland / Department of Health and N 1- State Registrar Certificate of Death		eneo 06 03784
				1. Decedent's Name (First, Middle, Last)	2. Date of Death	
		Physici /Medic		Samuel Brown Sr.	Month FEBRUAR	Day Year 9:39AM
-		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
				SINAI HOSPITAL OF BALTIMORE BALTIMORE		n/a
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 F Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
		Director		214-22-0229 123 84 Yrs. Usual Residence of Decedent	01-01-	1922 Virginia
	yland	MI		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	X a	P-1 si	tor	Md n/a Baltimore		XXYes 2 □ No
	h the	or 28	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
1	E W	23a d	aiD	3320 Ingleside Avenue 21215		USA
E.	r dea	S He	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
5	36 s afte	ei', or items 23s or 28e-f show Examiner mast be multified at	by Fu	1 Never Married 2 Married 1 Yes 2 No 5000 1 Yes 3 No 5000 1	,,	Specify: African- American
2	d 21215-0036 filed within 72 hours after death with the Maryland	"neturel", or items ofical Examiner in	d be	3 Notice of the street of the		
SA	15- 17-	"ne	Completed	15. Decedent's Education (Specify only highest grade completed) [Second work done during most of work life. DO NOT use retired)	ing	6b. Kind of Business/Industry
- 1	12 with	iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+)		Bethleham Steel
	D =	ntal Hygiene. ed other then event, the M	a)		e (First, Middle, M	
SR	a d big	fenta rked iic ev	To B	George Brown Lucy Fo	ostar T	rueheart
,	Maryland	th and Mental Hygiene. 7 is marked other then " treumetic event, the Max	-	19a Informant's Name/Relationship (Type Print) 19b Mailing Address (Street and Number or Burn	al Route Number,	City or Town, State, Zip Code)
Z	2			Deborah Hawkins/ Daughter 3320 Ingleside Av 20a. Mathod of Disposition (Name of cemetery, crematory or other place)	b. Bal	to. Md 21215
>	S 8	·		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		0c. Location - City or Town, State
20	Pages	ant: h		'4 Donation 5 Other (Specify) Arbutus Mem. Park 2-1;	3-06	Arbutus Md
2	Baltimo permit. Page	Department importent: any injury conce.		21. Signature Funeral Service Gensee 22. Name and Address of Facility $\overline{W}V$	lie F/H	PA of Balto.Co.
a	- a	Q E 9 9		William P200 Liberty Rd.	, Randa	llstown. MD 21133
				23. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac speck, or heart failure. List only one cause the each line.	or respiratory arres	Approximate Interval Between
	Ph	ysician		Immédiate Cause (Final disease or condition SEPS15		Onset and Death
		Medical kaminer		resulting in death) Due to (or as a consequence of):		
		Kanniner		Sequentially list conditions, b		
1	\ B	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Claese or if july) b. Due to (or as a consequence of):		
1,	V	and I-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
5	8760, https://aie.org/">https://aie.org	hysicion and the burial-transit		Sub-to-(of do d Consequence or).		
4		y e e	g	d		
	Box (attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Froun	Beath	atter d for u	cial	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)		Month Day Year
101	0 €	ed by the atte	hysi	9 Unknown		
K	Records, P.O. Box 6. The law requires that the death certific		by Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
- 1	rd a	been sign should be			1 🗌 Yes	2⊠No 3□Probabiy 4□Unknown
*	Record he law requir	2 sho	Completed		24a. Was an	24b. Were autopsy findings available
0	The Table	ate ha page	E		autopsy performe	prior to completion of cause of death? ☑ No 1 ☐ Yes 2 ☑ No
X		certificate rector, pag	BeC	25. Was case referred to medical examiner? 26. Place of Death	1 (Check only one)	
Cia	of Vita Physicien:	.g = 0	10 E		me 5 Residen	ce 6 ☐Other (Specify)
	_	h. After th funeral	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at linjury Work? 28c. Injury at linjury	28d. Describe how	injury occurred
	/ision Attending	death.	cati	2 Accident investigation M 1 Yes 2 No		
	Division or Attending	after death Director: I in by the	Certification:	Suicide 4 Homicide At Homicide See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	Hospitei	ers a				
16) 🖁	Fun Fun	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	and due to the cau ed at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
1	o the	within 24 hours after of To the Funerel Direct completely filled in by	Mec	20h Signatura and title of contition	290	d. Date signed (Month, Day, Year)
	, F	s i o		Illiana (Malore MD) REG DOD		2/08/2001
	•		1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		2,00,2006
		H	1.11	290. Signature and title of certainer Why Old M RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHENNA ERICA OKAGBUE SINAL HOSPIT 31. Date filed (Month, Day, Year) 2006 32. degistrar's Signature FEB 1 0 2006 32. degistrar's Signature Completed Cause of death (Item 23a) (Type, Print)	"AL OF	BALTIMORE
		Sta	te	31. Date filed (Month, Day, Year) FEB 1 0 2006 32. Registrar's Signature		
	H.	Registra	ar	FEB 1 0 2006		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February **Physician** 7, 2006 12:30 P M Mary Jane Benowsky /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1322 James Street Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year May 21, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F 217-34-7119 67 1938 Ohio Director Usuel Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Maryland N/ABaltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1322 James Street 21223 United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Item any injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony T. Jaguszewski Mary T. McCreedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Benowskyj / Daughter 1322 James Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Michael's Cemetery 2/10/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licensee 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence ivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 99 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1□ Yes To the Hospitel or Attending Physicien: Be tor: After this certific the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 KNatural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00026973 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4. W. ROLLING CRUSSROPIDS. TREAT-MINS NO 31. Date filed (Month, Day, Year) 32. Registrali's Signature State Registrar

Physician	
/Medical	
Examiner	

Funeral Director

filed within 72 hours after death with the Maryland item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be profitted at Il Hygiene. permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy importent: if item 27 is marked other any niury or other traumatic event, DDS.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> use as the burial-transit Bud ed by the ettending physiclan detached for use as the burial cate has been signed by page 2 should be detact certificate has l After

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physicien: death. filled in by the within 24 hours efter deat To the Funerel Director: ÷ 10+ Registrar

State of Maryland / Department of Health and Mental Hygiene UU h For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Louis J. Brewster FEBRUARY 2006 11:20 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Saint Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday). 85 Yrs. 8. Date of Birth Nov. 3, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 1 M 2 □ F 217-16-3637 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Phoenix 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12890 Eagles View Road 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No □ □ □ II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bell Atlantic Elementary/Secondary (0-12) College (1-4or 5+) Technician Telephone 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brewster Anna Stroemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Hartrantf/companion 732 Scarlett Drive Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/08/2006 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Apecify) Timonium, Maryland Dulaney Valley Mem Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD Stephen Coster 23a. Pant. Elia the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION DAYS Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ VALVULAR HEART DISEASE 2 XNo 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 21 Yeo ACUTE RENAL FAILURE 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation М 1 Tes 2 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08E D26637 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, OSLER DRIVE TOWSON MARYLAND 21204 7621 32. Registrar's Signature State 0 2006

State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 8, 2:20P M 2006 Madeline M. Bruns /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Rosedale Nursing Home Franklinwoods If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2/2 F 215-09-2942 91 11/22/1914 Maryland Director Usuel Residence of Decedent 10d. fnside City Limits the Maryland 10a, State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 € No Essex MD Baltimore Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number death with U.S.A. 21221 8620 Kelao Drive Apt. 209A by Funerai 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or Iter 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 ⊠Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charlotte (Unknown) Frank Medicus 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4109 Ravenhurst Circle Gle Arm, Maryland 21057 Joan Holthaus 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ita any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Evangelical Luth 2/11/06 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 m 23a. Part1. Enter the disease, or comblications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner tay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24e. Was an After this certificate has autopsy performed/ 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and tipe of certifier MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h Franklin Square Dr., Ste (anden MD eama 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			For State	State of Maryland		artment of H		, ,	2006	03788	
	4		Registrar 1. Decedent's Name (First, Middle, Last)			incate of L	Jeani	2 Date of Dea	Reg. Ne. O O O	3. Time of Death	
	Medical Nellie L. Campbe							Feb	3 200 g		
	Examir	ner	4a. Facility Name (If not institution, give .	itreet and number) Med. C+R		4b. City, Town, or	Bur	Nice	4c. County of De	ath 🔑	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth	9. B	irthplace (State or Foreign Country)	
	Director		219-62-5315 1 Usual Residence of Decedent	M 2₹ F	51 Yrs.	WOITING Days	riours with.	Jan 12	2 1955 N	Maryland	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Sa-fa	Director	Maryland Anne Ar	undel S	evern					1 ☐ Yes 2X No	
9	3a or 2	Dire	10e. Street and Number 1805 Battlement	Ct.		10f. Zip Code 21144	4		10g. Citizen of What (USA	Country?	
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f ahow int, the Medical Examination to Incillised at	Funeral	11. Marital Status 1 □ Never Married 2★2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No	It	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, Wh		
21215-0036	hours tural',	Completed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1973		I ☐ Yes ② ☐ ☐ Yes ☐ Occupa	Specify:	1	Specify: E		
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7	led wit lygiene her the		12th	4yrs	Bud	get Ana		(5)	<u>, , , , , , , , , , , , , , , , , , , </u>	Defense	
and	uid be fi fental H rked ot tic avar	To Be	17. Father's Name (First, Middle, Last) Herman Davis				Clarice		Maiden Sumame) DN		
Maryland	nd 2 shou alth and N 27 is ma		19a. Informant's Name/Relationship (Ty Arthur Campbell						r, City or Town, State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Experiment and be notified at ance.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State M	Majori emori	sition (Name of Watery of the Folace al Park	2-8-		20c. Location - City of Elkridge		
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service License	moc483	8	m ^{Name} Reess 21 West	St. Ann	Mortu napolis	nary, P.A s, Md. 21	401	
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	ficate be executed physicien and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
8760	cate be ohysici the bu	dicai									
Θ	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar					23d. Date of d	elivery	
.O. Box	the death by the atte- ached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						Month		
ds, P	The law requires that the death certified has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						d tobacco use cont <i>r</i> ibute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ŋ whicho		
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Division of Vital	ding Physician: The h. h. After this certificete ha funeral director, page	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing Ho		ence 6 Other (Sp ow injury occurred	өесіту)	
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<u>></u>	ai or Atten s after death if Diractor: od in by the	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		City or Tow	treet and Number or i n, State)	Hurai Houte Number,	
	To the Hospital or Attanding Physician: Within 24 hours after death. To the Funaral Diractor: After this certifica	edical (29a. Certifier (Check only one) 1 Certifying Physical Condition (Check only one)	and due to the cred at the time, d	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)						
=	To the within 2 To the complet	Ž	29b. Signature and title of certifier	Depo	144	29c. License		2	29d. Date signed (Mo.	nth, Day, Year)	
	140		30, Name and address of person who co	mpleted a se of death (Item	23a) (Type, I	Print)	meric		5		
	Sta	ite	31. Date filed (Month, Day, Year)	32: Registrar's Signat		75 77	meric	A	21035		
	Registr		FEB 1 0 200	187		Si.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year 100 2006 tebruary /Medical i. Facility Name (If no institution, give steet and nu altimore Renabilitation extended Care Cent 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 34.8838 1 M 2□ F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕍 No tarkv Completed by Funeral Director BALTIMORE 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code or Iteme 23a or 100 12. Was Decedent Ever in U.S. Amped Forces? 1 D Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🗘 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 VISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Mabe 2 DUIS 19b. Mailing Address (Street and Number or Rural R vte Number, dity or Town, State, Zip Code) 21093 Department of Health a Important: If Item 27 is any Injury or other train once. prother-in-law 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method or Display 1 Burial 2 A Cremation 5 Other (Specify) Date 3 Removal from State -10-06 21. Signature of Funeral 22. Name and Address of Facy WRICED: Timonium, MD 21093 PEACEFUL ACTERNATIVES FUNERAL-CREMATION CENTER 23a. Paft 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery signed by the atten I be detached for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig , page 2 should b 3 Probably 1 Yes 2 No 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2.20 No 1 Yes **Division of Vital** 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) this. funeral 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury within 24 hours after death.
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056505 10 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

SMAD

21218

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, 2006 **Physician** February Pei Cheng P M 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F December 15, 1923 China 433-43-3472 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: if item 27 is marked other then "natural" ..."

ery fully or other traumatic even. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Directo Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14411 Traville Garden Circle, #313 20850 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2 X No Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: ģ 3 Widowed 4 Divorced Asian Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Director of Forestry 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Government Bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jin Cheng Jun Tray Yu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada H. Cheng/Daughter 10601 Prairie Landing Terrace, North Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 7, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesa— Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Scensee lette Dansiste MO1305 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulfing in death) Acute MYOCArdial Infarction **Physician** minutes /Medical Due to (or as a consequence of) Examiner tears Coronary Artery Atheroscientic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transit resulting in death) Lasf Due to (or as a consequence of): Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2. No 1 Yes Division of Vital To the Hospital or Attending Physician: After this certification funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2☐ ER/Outpatient 3☐ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 0058025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Wenk, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 0 2006 Registrar

			1_ State	rtment of Health and Mental I	2006	03701
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No.UUU	3. Time of Death
	Physici		Mary Elizabeth Carlisle	Month Febru	Day Yea	
	/Medic Examin	(3)	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
	LAGITILI	C1	Wilson Health Care Center	Gaithersburg	Monte	omery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		f Birth 9. B	hirthplace (State or Foreign Country)
L	Director		218-24-6980 1□M 2\RF 77 Yrs.	Augus	st 31, 1928 Wa	shington D.C.
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Mary f sho	tor	Maryland Montgomery Montgomer	ry Village		1 X Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
	death with the Maryland rms 23e or 28e-f show r runst be notified at		18972 Montgomery Village Avenue	20886	United	States
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - Ar Black, WI	nerican Indian,
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15-0036	d within 72 hours after death with the Marylan jien e r then "naturel", or ftems 23e or 28e-1 show The Modical Examination and be notified at		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. Kind of Busines	2s/Industry
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<u>X</u>	Ment Ment arkec	To I		Phyliss (Unkr		
Maryland	d shand read			g Address (Street and Number or Rural Route Nu		
	1 and Healtl em 27 ther t		20a Method of Disposition 20b. Place of Dispos	Montgomery Village Avenue, Montgomery Village Avenue, Montgomery Date	lontgomery VIII:	
altimore,	ages int of t: If it		1 X Burial 2 □ Cremation 3 □ Removal from State Mt. Z101 Ba	patory or other place) February 9	,	, Maryland
	artme orten injury		Garage C	Adictory		
ñ	permit. Pages 1 and 2 should be fil Department of Health and Mental th Importent: If item 27 Ie marked oth eny injuy or other treumetic even <u>once.</u>			Name and Address of Facility Dert A. Pumphrey Funeral Ho West Montgomery Avenue, Ro		
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Rox	eath certific attending p	M/UR	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ IF Female 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ IF Female 1 ☐ Live birth 2 ☐ Live birth 2 ☐ Liv	Ectopic pregnancy	23d. Date of c	· ·
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Division of	or Attending Paffer death. Director: Affer fain by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. Location City of	on (Street and Number or r Town, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 112 Certifying Physician: To the best of my knowledge, death	popured at the time date and date and	the source(=)	To stated
	24 hc 24 hc Fun etely 1	Medical	29a. Certifier 1	estigation, in my opinion, death occurred at the tir	me, date and place, and d	as stated. ue to the cause(s)
	ro the within Fo the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)
	/		M. Robert Fire chler le	4 004115	Februar	45,2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, F	14 DO4/15 Print) 201 PUSSELL 1 GA-TTHERS BU	AUSNU	g No.
			31. Date filed (Month, Day, Year) FEB 1 0 2006 32. Registrar's Signature	GA-TTHERSBU	RE MAS	0777
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	3060		
	1,09,50		Les Davison of Land			

			rica									-		Legible.		
			1 _ State	518	ate of t	viaryiai			ent of F			ental H		11116	037	92
1,480	31. A.		Registrar 1. Decedent's Name (First, Middle	, Last)				Crance	210 01 1	Dealii		2. Date of D	Reg. N	0.000	3. Time	of Death
	Physici		Charles Thomas	Trutch	lev							Month Februa		ay 2006	6:51	A^{M}
	/Medio		4a. Facility Name (If not institution			er)		4b. Ci	ty, Town, or	r Location of		LCDIGC		c. County of Dea		
			Frederick Memor:	ial Ho	spita	1		Fre	deric	k			Fr	rederick		
D-	Funeral		5. Social Security Number	6. Sex 1 X M 2		Age (In yrs.		Month	der 1 Year is Days	If Under Hours	Min.	8. Date of B (Month, L	irth Day, Year	9. Bir	thplace (State	or Foreign
7. 10-11	Director		214-54-0015 Usual Residence of Decedent	123111 2		56	Yrs.				C	ct. 2	5, 1	949 Mar	yland	
L'action of the last of the la	Mo N		10a. State 10b. County			10c. Ci	ty, Town or	Location	- ·						10d. Inside	City Limits
Man	9	tor	Maryland Freder	lck		New	Marke	ti							1 ☐ Ye	s 2X No
book off the Maryland	inne. Ir then "natural", or Iteme 23e or 28e-1 ehow Ite Modical Examinat must be notified at	Director	10e. Street and Number						Zip Code				10g. C	itizen of What C	ountry?	
5	238		6636 Rockridge	Road					774				USA			
9	T D	Funerai	11. Marital Status	l An	med Force	nt Ever in U s?	.S. 1	3. Was De If Yes, s	cedent of H pecify Cuba	ispanic Ori an, Mexicar	igin? (Spec n, Puerto P	ify Yes or Nican, etc.)	lo-	14. Race - Am Black, Whi		
bours after	i, or	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	1 11 1	Yes 2[Yes, Give	⊒no s:1967-	72	1 🗆 Yes	2 ∑ No	Specify:				Specify:		
ZIZIO-0030	a gran	ted	15. Decedent	s Education		1907-	16a. De	cedent's U	sual Occup	ation			16b. I	Wh Kind of Business	ite /Industry	
. 1 Z 1 3-1	Med 7	Completed	(Specify only highes Elementary/Secondary (0-12)		pleted) illege (1-4d	or 5+)	(G)	ve kind of DO NO	work done d use retired	during mos. d)	it of workin	g			,	
	/gien	Con	12				Cour	se Me	chani	.c			Go1	f Cours	e	
= 9	a d b	Be	17. Father's Name (First, Middle, I	.ast)						18. Mothe	er's Name	(First, Middl	e, Maide	n Sumame)		
	and Mental	ို	Lewis Edward Cri									e Knil				
۰ 🖺	f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationsh										-	or Town, State,		
a)	Healt Healt Her		Wendy Crutchley 20a. Method of Disposition	wire		20b. F	0636 Place of Dis	KOCK position (A	ridge lame of	Road	ı, Nev			Marylan ocation · City or		/4
	2° = 5		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (St		al from Sta	10	emetery, c Lthsbi				10.120	06		•		and
	Departmer Important eny Injury		21. Signature of Funeral Service I			SIII.	LUISDO	-		-				thsburg sford F		
ä	Depa Impo eny l		Keran M.	#501	GLA.	м00	999							rick, M		
*	No. W.		23a. Part1. Enjer he disease, or shock, or he intailure. List	complication	that caus	sed the deat								- TO HE SEE	Approxima Interval Be	ate
P	hysician		Immediate Cause (Final disease or condition			scler									Onset and	
	/Medical xaminer		resulting in death)			as a conseq										
The same	Adminier	Ļ	Sequentially list conditions,	b	D	as a conseq										
7	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or .	as a conseq	uence or):									
ou, C	n and ial-tra	Exar	that initiated events resulting in death) Last	cf	Due to (or	as a conseq	uence of):									
- 0	been signed by the ettending physicien and should be detached for use as the burial-transit	cail		d												
	ng ph as th	ledi	IF FEMALE.													
th cert	tendii or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?			ne of pregna 2 Feta		3 Ectopic	pregnancy					23d. Date of de		V
) e	the et hed fo	Physician/Med	1 Yes 2 No		Pregnant Unknown	at time of d		Other					į	Month	Day	Year
The law requires that the death certifical	ad by detac	Ph	Part II. Other significant conditio	ns contributii	ng to death	but not res	ulting in the	underlying	CALISA DIVE	an in Part I		23e Did	tobacco	use contribute to	the cause of	death?
ecords,	sign Id be	d by	Diabetes, Hyper						, and a give		•		Yes 2		obably 4	
5 §	shou	Completed										24a. Wa	s an	24h Were a	stoney findings	available
בי קר בי קר	e has age 2	dmo										auto	opsy formed?	death?	topsy findings completion of	cause of
	rtifice tor, p	a l	25. Was case referred to medical							26. Place	of Death	1 ☐ Yes Check only	2X No	o 1 Ll Yes	2 □ No	
Attending Physician:	direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospita	il: 1 🗌 Inpa	atient 2	ER/Outpat	ent 3 🗆	Othe Othe					6 ☐Other (Spe	city)	
	Viter ti		27. Manner of Death 1 X Natural 5 ☐ Pending	28a	n. Date of Ir (Month, I	njury Da <i>y</i> Yea <i>r)</i>	28b. Time Injun	/	28c. Injury Work	at c?				iry occurred		
or Attending	for: f	cati	2 Accident investig 3 Suicide 6 Could n	ot ho				М		Yes 2 1						
	Direction by	Certification;	4 Homicide determi		building,	Injury - At he etc. <i>(Specif</i>	ome, tarm,	street, fact	ory, office		28	City or To	(Street a own, Stat	nd Number or Ri e)	ural Route Nui	mber,
Lo the Hospital or	within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2 s		29a. Certifier 1 ☐ Certifying	Physician:	To the be	st of my kno	wledge, de	ath occurre	nd at the tim	ne date and	d place, an	nd due to the	a cause/s	s) and manner as	stated	
Ho Ho	Full Full Hetely	edicai	(Check only 2 Medical E	xaminer: O	n the basis	of examina	tion and/or	investigati	on, in my op	oinion, deal	th occurred	at the time	, date an	d place, and due	to the cause	(s)
Toth	withir To th	Me	29b. Signature and title of certifier	0	11		7	/ 2	9c. License	number			29d. Da	ate signed (Mont	h, Dey, Year)	
			· Cagure	12		dy	X		040307	7			Febr	uary 9,	2006	
	10		30. Name and address of person v													
	V		Eugene B. Casagi	ande,		1564 strar's Signa		umtow	n Pik	e, Fr	ederi	Lck, M	ப 2	1702		
	Sta Registr		FFR 1	0 2008	S. A.		M	Bourse	e si							

Jacque 06-009 crn		ar	garet Clunk Please 1 Unpend item#23a,	ype or Prin 27 perME (38 State of Ma	it in B 52,2/2 aryland	l ack In 2706 Th	delibl artmer	e Ink. nt of H	Ensure A	II Copie Mental H	s Are	Legible.	
			1 - For State Registrar						Death		Reg. N		03793
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Jacqueline M. Cl							2. Date of D Month Februa	Da	ay Year 05, 2006	
	Examin		4a. Facility Name (If not institution, give						Location of Death		_	c. County of De	
10			3417 Ravenwood Av 5. Social Security Number 6. Sec		a (In vrs la	ast birthday)		Balti	MOre If Under 24 Hrs.	8. Date of B	lirth	N/A	inthplace (State or Foreign
200	Funeral Director			M 2ØF 5		Yrs.	Months		Hours Min.	Sept.	Day, Year	r) (Maryland
	Maryland -f ehow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	ith with the Marylar 23a or 28a-f ehow	Director	Maryland N/A						imore				1.X Yes 2 □ No
	with the	5	10e. Street and Number				10f. Zi	p Code	0.1.0		10g. C	itizen of What C	
	ne 23	Funeral	3417 Ravenwood Av	12. Was Decedent B	Ever in U.S	S. 13. V	Vas Dece		213 spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or N	10-	U. S.	
Maryland 21215-0036	filed within 72 hours after deeth Hygiene. ther then "natural", or tlems 23 int. the Madical Exeminer must	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			fYes, spe □Yes		n, Mexican, Puerto Specify:	Rican, etc.)		Black, Wh Specify:	ite, etc. hite
5-0	72 hc	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	kind of w	ork done d	during most of work	ang .	16b. I	Kind of Busines	s/Industry
121	within ene. then	e Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT I	ise retired	ion Teac		C	tata a/	Maryland
d 2	filed Hygid other	င်	17. Father's Name (First, Middle, Last)	1 year		Specia	u E	ueur	18. Mother's Nam				Maryland
/lan	12 should be filed within in and Mental Hygiene. 7 ie marked other then " raumatic event, the Mad	To B	Elmer G. Clunk						Marg	aret M.	. McA	Manus	
lan	es 1 and 2 should b of Health and Ment I tem 27 ie markec r other traumatic e		19a. Informant's Name/Relationship (Ty						and Number or Ru		-		
e,	1 and Health		Thomas Clunk (Bro. 20a. Method of Disposition	tner)	20b. PI					t 424,		CUMOTE, Location - City o	Md. 21218
nor	ages ant of I t: if the y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		ace of Dispo emetery, cren VLKWOOO			ı		12.		
Baltimore,	permit. Pages Department of I Important: If Its any injury or of once.		21. Signature of Funeral Service Licens	90	ru				ss of Facility Sch				Maryland
ä	Ped in a		Frim 2 Jein			3.	331 E	Brehm	s Lane, i	Baltimo	re,		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resutting in death) Sequentially list conditions.	Coronary a	^{18.} Can artery	diomega diseas	Ly wit		g, such as cardiac entricular			nd	Approximate Interval Between Onset and Death
	ecuted nd transit	amlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	ence of).							
,09	licate be executed physicien and s the burial-transit	Ä	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):							
68760,	ficate physics the	adlo											
Вох	Attending Physicien: The law requires that the death certificate be exe or death. closth. ctor: After this certificate hes been signed by the ettending physicien a ector. After this certificate hes been signed by the ettending physicien a by the funeral director, page 2 should be detached for use as the burial-	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 05⊌nknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p Dther (s	regnancy pecify)				23d. Date of do	elivery Day Year
, P.(es that th igned by be detac	by Ph)	Part II. Other significant conditions cor	ntributing to death bu	ut not resu	Iting in the ur	nderlying	cause give	en in Part I.	23e. Did	1 tobacco	use contribute	to the cause of death?
ğ	w require been sig should b	ted t								1]Yes 2	2 □ No 3 □ F	robably 4 Dunknown
မိ	fawr nes be	Completed								24a. Wa	opsy	prior to	autopsy findings available completion of cause of
<u>~</u>	: The cate h										formed? 2□N	death?	s 2 No
∠jt	ystclan: The taw is certificate hes I director, page 2 s	Be c	25. Was case referred to medical examiner? 1 Xyes 2 No	lospital:				OA Othe	26. Place of Deat			-37	
õ	Phys er this eral di	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatien 28b. Time of		28c. Injury Work	4 LI Nuising no	ome 5 ☐ Re 28d. Describe			ecity) at scene
ion	uttending I death. ctor: After y the funer	atlo	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year)	Injury	м		(? Yes 2 □ No				
Division of Vital Records, P.O.	al or Atte s after de et Directo ed in by th	Certification:	3 Suicide 5 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At ho	me, farm, str	eet, factor	y, office			(Street a own, Stai		Rural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a Certifier (Check only one) 1 Certifying Physical Exami	ner: On the basis of and manner sta	examinat	vladge, death ion and/or inv	estigation	sat the time, in my op	ne date and place, pinion, death occur	and due to the red at the time	a causa(i a, date ar	t) and manner t nd place, and di	e to the cause(s)
	To the To the Comple	ž	29b. Signature and title of certifier				29	c. License	number		29d. D	ate signed (Mor	nth, Day, Year)
			· llue/2					O.C	.M.E.		Feb	ruary 0	6, 2006
			30. Name and address of person who co	mpleted cause of de	eath (Item			Str	eet, Balt	imore	Mar	vland ?	1201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	_	ure		DUL	LLL, DALL		TICIL	yrana 2	1201
	Registr		FER 1 0 2006	Recues	K	ASION							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nb. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician DULAN in BERLES 7ebruary 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ranklin Square Kosedale Himore Hospita enter Year If Under 24 Hrs. If Under 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 7226 1□M 250F Yrs. 312 82 Director Usual Residence of Decedent 10b County 10c. City. Town or Location 10a State 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be mutilisd at 1 ☐ Yes 2 No Directo Margrano BALTIMORE RRY HAL 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō items 23a OUR 21236 P.2. 101 3/1/2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 250 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married > Married land 212/15-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 5HUZ HOPKINS other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene SPIRATORY THERAPISHI 27RS. 12785-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event once. Be Simmone FRZYER KSAI HELAINS HARRY J. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ERRY HALL SALVATORE 101 12/12 INO/LACO Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition FIB.13, Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDINS OF FAITH DARKERAL 2006 LIAO3ZD) 22. Name and Address of Facility
EVANS ENTARRISTOR ROAD PARKY WE MANAGED AND PARKY WE MANAGED ADDRESS 21. Signalum II Funeral Serves Licensee. 2434 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner potenSion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed bS15 that initiated events resulting in death) Last Due to (or s a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. Completed by 1☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificete 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No I Director: A d in by the ft investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by determined 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058371

DHMH 17 Rev 1/2001

State

Registrar

Square

ive Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Franklin

32. registrar's Signature

960

31. Date filed (Month.

109/2006

		1 - For Stata Registrar	State of	Marylar	nd / Depa	artment o	f Health of Death	and M	fental Hy	/giene	006	5 03	795
Dhue		1. Decedent's Name (First, Middle, L.	ast)						2. Date of D	eath			ne of Death
Physi /Med		Eleanor M. De	la Cruz						Februa	ıry 6	, 20ď	6 2.	07A M
Exam		4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City, Tow	n, or Location	of Death		4c.	County of I		0771
		Mariner Health	Care of	Bethes	da	Bethes	sda			M	lontgo	merv	
Funera	al			. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under		8. Date of Bi	rth		Birthplace (S	ate or Foreign
Directo	r	030-03-3100	1□M 2∭F	93	Yrs.	Months Da	ys Hours	Min.	Oct. 3	$1 \cdot 1$		Vew Yor	
p ×		Usual Residence of Decedent 10a, State 10b, County											
aryla	=	10a. State 10b. County		10c. Cit	ly, Town or Lo	cation						10d. Insi	de City Limits
M 98-1	Sc.	Maryland Montgon	nery	Be	thesda	L						10	Yes 2X No
vith t	Director	10e. Street and Number				10f. Zip Cod	ө			10g. Citi	zen of Wha	t Country?	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f ahow he Medical Exeminer must be ricitified at	Completed by Funeral	5807 Linder Lane				20817				Unit	ed St	ates	
er de	E E	11. Marital Status	12. Was Deced Armed Force	ent Ever in U. es?	.S. 13.	Was Decedent of f Yes, specify C	of Hispanic Or	rigin? (Spe	ecify Yes or No	D-		American India	n,
36 saft	Ž.	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Tes 2		1	1□Yes 2X			, , , , , , , , , , , , , , , , , , , ,		Consider		
21215-0036 ad within 72 hours aft glene. ar than "natural", or in the Medical Exemi	D D	323 Widowed 4 Divorced	Year or Dat	es:							Specify:	White	
15.	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Oct kind of work do DO NOT use ret	cupation ne during mos	st of worki	ng	16b. Kir	nd of Busine	ess/Industry	
C sitial	Ę	Elementary/Secondary (0-12)	Cotlege (1-4	lor 5+)	_		irea)			_		/	
D PER T	Ö	17. Father's Name (First, Middle, Last	')		Sect	etary	10 Moth	odo Nome	(First, Middle			an/Barl	oer Sho
d be ontail	Be	Lawrence Moran	,								Sumame)		
Maryland 2 should be file th and Mental Hy 7 le marked oth	2	19a. Informant's Name/Relationship (Tuna Print)		105 14-11-	- 4 4 4 7 7 70 1			. McBri				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or Itama 23a or 28a-1 ahow any Injury or other traumatic event, the Medical Examinat must be profitted at		Peter de la Cruz	**		4	g Address (Stre							
Hoel Tan		20a. Method of Disposition	2011	20h P	3807	Linder		_	-				
altimore, mit. Pages 1 ar pertment of Hee portant: If Itam y Injury or other		1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from St		emeterv, cren	natory or other r	lace) F	ebrű	-	20¢. Lo	ation - City	or Town, Stat	6
time right		4 Donation 5 Other (Special		Cre	matori	um, Inc		3, 20		Bet	hesda	, Mary	Land
Ba Depe Depe		21. Signature of Emperal Service Licer	13		Be	Name and Add	ress of Facilit	y Robe Chase	ert A.	Pump	hrey	Funeral	Home/
- 402.00		1/ Carile	leur	. моов	De De	thesaa.	Maryi	and	20014-	TUCE	/ WIS	consin	Avenue
Physiciar		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	One Cause on eac	at tirte.		er the mode of d		cardiac o	r respiratory a	rrest,		Approx Interval Onset a	mate Between ind Death
/Medica		resulting in death)		as a consequ		lyopathy						-	
Examine		Constitution of the second		monia									
Un .	je l	Sequentially list conditions, if any, leading to mine diate cause. Enter Underlying		as a consequ	anius ot).								
68 / 60, ficate be executed physicien and is the burial-transit	Examine	that initiated events	c										
O, en al rial-t	EX	resulting in death) Last	Due to (or	as a consequ	ience of):							=====	-
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death certific	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnar						2	3d. Date of	delivery	
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d age	Certification:	4 Homicide determined	building,	etc. (Specify))	or, raciory, orrice	,	-	City or Tow	m, State)	rvumber or	nurai noute N	umber,
To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral completely filled in by the funeral presence.		29a. Certifier 1♣ Cartifying Ph	ysician: To the he	st of my know	vledge, death	Occurred at the	time date acc	1 place or	nd due to the	Due 2/-1	nd w	e e etct - d	
A Ho 124 Fu 19 Fu	Medical	(Check only 2 Madical Examone)	inar: On the basis and manner		on and/or inve	estigation, in my	opinion, death	h occurred	d at the time, o	ause(s) a date and p	na manner lace, and d	as stated. ue to the caus	e(s)
To th Mithir Fo th	Me	29b. Signature and title of certifier			A	29c. Licer	ise number			29d. Date	signed /Mo	nth, Day, Yea	r)
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01		30. Name and address of person who	completed cause of	f death (Itom	23a) /Tunn 17		7660				-/-		
7						nnı) 11e Pike	e. #c10)() P	002271	۱۵ ۱	farul -	nd 20	852
St	ate	31. Date filed (Month, Day, Year)		strar's Signatu	ILE		# GI	, K	OCKVII	16, L	iaryta	111u 2U	052
Regist		EED 1 0 00	00	1.	. 1	A. a							

DONALD E. DINAGEN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00913 State of Maryland / Department of Health and Mental Hygiene RJ 1 - For State Registrar Reg. No. UU 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Дау 5, **Physician** 2006° 4:07 р.м Donald Edward Inagen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital ER Rockville Montgomery County If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8-5-1932 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F 73 Yrs. 038-20-0572 Director Rhode Island Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itema 23a or 28e-f ahow other traumatic avent, the Medical Examinar must be notified at Gaithersburg MD 1 Yes 2 No **Funeral Director** Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20875 426 Girard USA #104 12. Was Decedent Ever in U.S. Armed Forces?
1 Dayes 2 □ No
If Yes, Give Year or Dates: 1955-73 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 10 ourier permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Itam 27 is marked other any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Redina Dinagen James lare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan (Mindte/Common Lawwife 426 Girard St. #104 Graithers bury MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesa peake Crematory Beltsville, MD 2-10-06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral + Cremation Services 21. Signature of Funeral Service Licensee 933 Grist Ave. Silver Spring, Mb 20910 mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a ATHEROLCLEDOTIC CARDIO MARCUAR /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Dusto (or as a consequence of). the attending physicien and thed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARUMONA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1. □ Yes 2 □ No certificate 1⊠Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1X Yes 2 No 2 XER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospitel 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge death occurred at the time data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

31. Date liled (Month, Day, Year) State

29b. Signature and title of certifier

FEB 1 0 2006

med

B10 H() 32. gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, MD 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year) February 6, 2006

	1 - For	te jistrar		S	State o	of Mary	yland		artmer tifica				ental Hy	giene Reg. No.	06	03797
* * * * *	1. Dece		(First, Middle,	Last)									2. Date of De	ath Day	Year	3. Time of Death
Physician /Medical		7	Hele	en	I	Duray							Month -	08-	06	1:05 PM
Examiner	4. 6 7	ity Name (If r	not institution,	give stre	et and nu	ımber)	-		4b. City	, Town, or	Location	of Death		4c. Co	unty of Deat	
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Funeral Director	220-	Security Nur -74-64	52	6. Sex 1 ☐ M	2[X F	7. Age (II	-	st birthday) 7 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da November	ⁿ , Year) 5,1908	Co	hplace (State or Foreign untry)
and	10a. Sta	esidence of D	10b. County			10	Oc. City,	Town or Lo	cation							10d. Inside City Limits
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with the Mar s or 28a-f el be notified	10e. Str	et and Numb							1	p Code				10g. Citizer	of What Co	untry?
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after or ft			d 2 Marrie	ed	1 Tyes If Yes, G	ive X No			1 🗆 Yes		Specify		,			ite
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ng Ph ng Ph fter th ineral		ner of Death Natural	5 Pendin		28a. Date (Mo	e of Injury onth, Day Y	'ear)	28b. Time o Injury	f	28c. Injur Wor	y at k?		28d. Describe			
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or At utter d birect in by		Homicide	determi	ined	28e. Plac	ding, etc. (Specify	me, farm, sti	reet, facto	ry, office			City or To	street and r wn, State)	rumper or∺	ural Route Number,
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Division of V To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by tha funeral directors.	5 (0				r: On the		caminati									e to the cause(s)
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			For State Registrar	State of Ma	arylan			ent of H		nd Me		giene	100	5	037	198
	DI		Decedent's Name (First, Middle, L.	ast)					-		2. Date of Dea	th		ear	3. Time o	
	Physici /Medi		Rosetta Rut		00		,				Feb	8	20		183	39 PM
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	Funeral Director			Sex 7.Ag 1□M 2∏XF	e (ip yrs. 78	last birthday) Yrs.	Month		Hours	Min	8. Date of Birth (Month, Day September	Year)	1927	Coun		or Foreign rqinia
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	with t	Funeral Director	6908 North Point	- Dood				Zip Code 21219					izen of Wha	at Coun	try?	
	ne 23	era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was De	cedent of H	ispanic Origi	in? (Spec	cify Yes or No-	US	14. Race -	Americ	an Indian.	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e or 28e-f show any Injury or other treumatic event, Ira Madical Examinar must be notilled at ance.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give			If Yes, s	pecify Cuba 2€ No	n, Mexican, Specify:	Puerto R	lican, etc.)			White,	etc.	
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Mar	12 sh h and h and le m		19a. Informant's Name/Relationship								Route Numbe			ate, Zip	Code)	
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.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	Ectopic Other	pregnancy (specify)					23d. Date o Month		ry Day	Year
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Division of	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not to determine of the determined investigation of	OB Plans of Init	ury - At ho c. <i>(Specil</i>)	ome, farm, str y)	M eet, fact		Yes 2 □ No		Bf. Location (Si City or Town			or Rura	Route Nur	nber,
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	To th withir To th comp	Me	29b. Signature and title of certifier				2	9c. License	number		2	9d. Da	te signed (//	Aonth, L	Day, Year)	
	1		- XXIII	MID.				Do	062	157	3	d	1/8/	06		
	h		30. Name and address of Jerson who	completed cause of d	eath (Item						-1					
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		1 - For State Registrar	•	Department of Health and Certificate of Death	d Mental Hy	giene Reg/No.006	03799
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Anthony George December 1. Anthony George 1. Anthony George 1	treet and number)	y Gerard Durmowicz 4b. City, Town, or Location of De Baltimore City	1	Day Year O 7 ZOD 4c. County of Dea	th
Funeral Director		220 22 7705	7. Age (In yrs. last to 76	oirthday) tf Under 1 Year If Under 24 F Yrs. Months Days Hours M	Sept. 2	9. Bir C Ma	thplace (State or Foreign puntry) ryland
Maryland a-f show	ctor	Usuet Residence of Decedent 10a. State 10b. County Maryland		more City			10d. Inside City Limits 1 X Yes 2 ☐ No
3a or 28	i Director	10e. Street and Number 6401 Loch Raven Blv	rd.	10f. Zip Code 21239		10g. Citizen of What Co United Sta	
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified all	by Funerai		2. Was Decedent Ever in U.S. Amed Forces? 1 MaYes 2 □ No If Yes, Give Year or Dates: Kore a	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 X No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi Specify:	
- 22	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then any injury or other traumatic event, the Magnee.	To Be Cor	17. Father's Name (First, Middle, Last) Anthony Durmer	4 5		Name (First, Middle,		pany
d 2 should be th and Mental t7 Is marked of trsumatic eve	F	19a. Informant's Name/Relationship (Ty) Anthony G. Durmowi		9b. Mailing Address (Street and Number or 1865 Still Creek Lane			
Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 □ Qurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	ceme	of Disposition (Name of tery, crematory or other place) ey Valley Memorial Gdns.	Date 2.11.06	20c. Location - City or	
permit. P Departme Importan any injury		21. Signature of Furer: Service License		22. Name and Address of Facility F Dulaney Valley, P.A. 2	rian T, Chi	sholm Funeral	Services of
Physician /Medical Examiner prize pr	ical Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only on trimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du	NZA ALOPATHY	nac or respiratory at	Test,	Approximate Interval Between Onset and Death
ro the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death, within 24 hours after death, to the Funeral Director; After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 \(\text{Live birth} \) 2 \(\text{Fetel dea} \) 4 \(\text{Pregnant at time of death} \) 9 \(\text{Unknown} \)			23d. Date of de Month	livery Day Year
fuires that I n signed by uld be deta		Part II. Other significant conditions con CHROW1 COBST	tributing to death but not resulting			obacco use contribute t Yes 2 No 3 P	o the cause of death?
The law rec cate has bee page 2 shor	Completed by			•	24a. Was autop perio 1 🗌 Yes	an 24b. Were a prior to death? 2 No 1 Yes	utopsy findings available completion of cause of s 28 No
ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: Inpatient 2 ER/	Other	Death (Check only of g Home 5 🗆 Resid	one) dence 6 □Other (Spe	ecify)
anding Phath. or: After the		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	o. Time of lnjury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe I	how injury occurred	
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (City or Tox	Street and Number or R wn, State)	ural Route Number,
e Hospi 24 hour e Funer etely fills	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	ige, death occurred at the time, date and pl and/or investigation, in my opinion, death o	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the comple	Me	29b. Signature and title of certifier	ne is as	29c. License number		29d. Date signed (Mon	
0		30. Name and address of person who co	RISIDEA mpleted cause of death (Item 23)	a) (Type, Print)		02/07	
0		31. Date filed (Month, Day, Year)	NG, 5601 L	OCH RAVEN, B	BALTIM	ORE, MU	> 2(239
Sta Regist		FFR 1 0 200	6 Augus K	South !			

ORIGINAL

		•	1 - For State Registrar	State of M	larylan		artmen rtificat			and Me		iene	06	038	00
	Disconini		1. Decedent's Name (First, Middle, La								2. Date of Deat Month	h Day	Year	3. Time of	f Death
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)	Examir		4a. Facifity Name (If not institution, give				4b. City,		Location o	of Death		1	ty of Death		
			Greater Baltimo						wson	0411-0		Ва	ltimo		
	Funeral Director		,	Sex 7. A	ge (In yrs. I 72	ast birthday) Yrs.	If Under Months		If Under:	Min.	8. Date of Birth (Month, Day, Oct. 18	, 1933	9. Birthr	olace (State ontry) orida	or Foreign
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	158 288 no.	Funeral Director	10e. Street and Number				10f. Zip	Code			11	Og. Citizen of	f What Cou	ntry?	
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æ	after or its	Ē	1 Never Married 2 Married	Armed Forces 1 Tyes 2 If Yes, Give	, No		ir Yes,speo 1 □ Yes			i, Puerto F	iican, etc.)		ack, White,		
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ζις O	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show the Medical Examiner must be malified at	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ition luring most	t of workin	g	16b. Kind of	Business/In	dustry	
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Ž	should the nd Men	ဥ	19a. Informant's Name/Relationship			19b Maili	na Address	/Street a			Route Number,	City or Town	n State Zic	Code)	
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ē	0 0		1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			emetery, crei 11top				2-10-	-06	Towso	on, Md	1	
Baltimore,	를 들는 다른 ·		21. Signature of Funeral Service Lice	4	1		2. Name ar	nd Addres	s of Facilit	ty				••	
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Division	or Attending efter death. Director: After in by the fune	fica	3 Suicide 6 Could not b	99 Place of le	njury - At ho	me, farm, sti	eet, facton				8f. Location (St		nber or Run	al Route Num	nber,
Ö	effer Olive d in b	Certification:	4 Homicide		itc. (Specify			,			City or Town	, State)			
	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying P	nysician: To the bes	t of my kno	wledge, deat	h occurred	at the tim	e, date an	d place, a	nd due to the ca	use(s) and n	nanner as s	stated.	
	ne Ho	edicai	(Check only 2 Medical Example)	miner: On the basis and manner s		ion and/or in	vestigation	, in my op	oinion, dea	th occurre	d at the time, da	ate and place	, and due to	o the cause(s	5)
	To the To the To the Comp	Σ	29b. Signature and title of certifier				290	c. License	number	2 9	29	9d. Date sign	ied (Month,	Day, Year)	
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	Registr	rar	FFR T A S	UUO AA	KS 10	14									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Beverly Egnew 0052 м 5, February 2006 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/25/52 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 21/21/F 53 Yrs. 542-60-2426 Portland, OR Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits OR Polk Salem 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 193 McMary Street, N.W. 97304 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💹 No Specify: White 3 ☐ Widowed 4 XX ivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Blood Services Coordinator Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Shearer Nora Voight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerri Castillo, Daughter 874 Quince Orchard, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/9/06 Beltsville, MD 4 □Donation 5 □ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Rapp Funeral and Cremation Services MO0382 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest, 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) www.onar Knan Due to (or as a consequence of): rerstil wor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide

Physician /Medical Examiner The law requires that the death certificate be executed has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Physician

/Medical

Examiner

Completed by Funeral Director

Be

Examiner

Certification: To Be Completed by Physician/Medical

Funeral

Director

or other traumatic event.

permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important: if Item 27 is marked oth any liuly or other traumatic event 2008.

timore.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a Certifier

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2006

death (Item 23a) (Type, Print)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** FLLIOI VER 8:30 A M 08 2006 FEBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death **Examiner** Secours Battimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, 5. Social Security Number 214–58 – 983 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 F Months Days Hours ntry 53 Yrs. irgina Director Usual Residence of Decedent 10d. Inside Lity Limits 10b. County 10c. City, Town or Location 10a. State itam 27 is markad other than "naturel", or Itams 23a or 28a-f shov other treumstic event, the Medical Examiner must be notified at 1 Ves 2 □ No Marylana Director 10e. Street and Numb 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Œ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental John Henryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #113 Informant's Name/Relationship (Type, Print) Hood nother Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ita 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland injury 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundry Service License Appromate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) D15E1952 DAYS Physician ALCOHOLIC L)VER 12 /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC D15EASE LNENDINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial-t the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by aked to me /// // // vision of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊕tinknown Completed peen 2938 A 3 624a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 22NG CHRONIC has N autopsy performed? page this certificate SUBSTANCE 2 No 1 ☐ Yes 2 ☑ No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Yes 2 (TUN) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours Iter death To the Funaral Director: in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wn. D 23300 FEBRUARY 08 2001 SELUVES HOSP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Refistrar's Signature

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31. Date filed (Month, Day, Year)

0 2006

				artment of Health and M rtificate of Death		iene 24006	03804
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Dea _Month	th Day Year	3. Time of Death
1	/Medi	cal	David Evans		Februai	cy 9, 2006	3:10 a M
7	Exami	ner	4a. Facility Name (If not institution, give street and number) 4013 Jay Em Circle	4b. City, Town, or Location of Death Ellicott City		4c. County of Dear	th
		à	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8 Date of Birth		hplace (State or Foreign
	Funeral Director		220-34-6991 XXM 2 F 65 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day) Oct. 23	Year) Co	ryland
Proc.	7		Usual Residence of Decedent		20,	TIME	yrana
	n the Maryland r 28e-f ehow	L	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	Be-f	acto	Maryland Prince Georges Greenbelt				1 □ Yes \$\(\overline{\ove
	with t	Funeral Directo	10e. Street and Number	10f. Zip Code 20770		0g. Citizen of What Co	ountry?
	eath w	erai	42J Ridge Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.			J.S.A.	rican Indian
(0	riten	Fun	Armed Forces? 1 □ Never Married 2 🖾 Married 1 □ Yes 🖾 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit	
036	hours after death with the Maryland urel', or Iteme 23a or 28e-f ehow al Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 🗛 o Specify:		Specify: Wh	ite
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121	d within giene. ir then "	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
		ပိ	12 Prin	18. Mother's Name		rederal Gov	ernment
ano	Q 22 D 9	o Be	Joseph Theodore Evans	Mary Mada	, , , , , , , , , , , , , , , , , , , ,		
Maryland	2 should be and Mental is marked o	2		ng Address (Street and Number or Rural			Zip Code)
	0 =	3		Jay Em Circle, Ell			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any njury or other treumatic 2005s.		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date)	ate	20c. Location - City or	Town, State
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alt	permit. Departr Importa any nji		21 Signature of Funeral Suita Licensee 22	Name and Address of Facility Bruzdzinski	Funoral	Homo D A	-
	207			40/ Old Eastern Av	renue, E	ssex, Mary	land 21221
			33. Part1. Sher the disease, or complications that caused the death. Do not ent shock or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Liver Metastasis				Onset and Death 5 months
	/Medical Examiner		Due to (or as a consequence of):				4
		ا <u>ت</u>	Sequentially list conditions, if any, leading to minediate b. Bladder Cancer				1 year
	uted 3 ansit	Examiner	Sequentially list conditions, if any, reading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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Ö	- 5 to	jete			24a. Was a	24b. Were au	topsy findings available
Re	0 = 0	Completed			autops	v prior to d	completion of cause of
	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death		a)	
_	Physicien: rthis certific ral director,	To	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Hom	ie 5 ☐ Reside	nce 6∰Qther(Spec	ter's Residence
D C	ding Pl h. After ti funera		27. Manner of Death XXINatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe ho	w injury occurred	
sio	Attending Physicien: r death. ector: After this certifici by the funeral director.	cati	2 Accident investigation	M 1 Yes 2 No			
Division	or Al after of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office 2	8t. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: . completely filled in by the f		29a. Certifier Check out. Check out. Check out. Check out. Descripting Physician: To the best of my knowledge, death	occurred at the time, date and place, or	nd due to the se	usels) and massar as	etated
	P Ho	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occurre	d at the time, da	ate and place, and due	to the cause(s)
	withir To th	M	29b. Signature and title of certifier	29c. License number	25	d. Date signed (Monti	n, Day, Year)
	9		I Edward I her my	DZ3601		02/09/	06
11			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	and No.		Edward J. Lee, M.D., 11065 Little Pate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	uxent Parkway, Colu	mbia, M	Maryland 21	044
	Sta Registi			sile			

			For State Registrar	State of N	laryland / Dep <i>Ce</i>	artment of Hertificate of I			iene eg. No.	06 (380)5
.Sp)	/ *ss a	2%	1. Decedent's Name (First, Middle, Last)				2. Date of Deal	th Day	Year	3. Time of	Death
	Physici /Medic		Edward E. Fruhlin	na. Sr.				02	02	2006	1:20	PM M
5	Examin		4a. Facility Name (If not institution, give		7)	4b. Cily, Town, or	Location of De	ath	4c. Co	unty of Death		
		g SAC	915 Pine Road			Joppa			Ha	arford		
	Funeral		5. Social Security Number 6. Se		ge (In yrs. last birthday		If Under 24 H Hours Mi		Year)	9. Birthp	lace (State or	r Foreign
1	Director		029-09-0875	Ž M 2□F	89 Yrs.			10/28/19	16	Mar	yland	
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside Cit	by Limite
	sho	2	Toa. State Tob. County		Too. Only, Town or E	Oution					1 🗆 Yes	
	8a-f	Director	MD Harford	5	Joppa	1 2 2 2				(10)		
	vith ti	盲	10e. Street and Number			10f. Zip Code		'	og. Citizei	of What Cour	ntry ?	
	ath v	Ta l	915 Pine Road			21085		10 11 11	U.S		and the attention	
	iurs after death with the Marylan al', or items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	:?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	erto Rican, etc.)	14.	Race - Americ Black, White,		
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 [If Yes, Give Year or Dates		1 ☐ Yes 2X No	Specify:		Sp	ecify:	_ _	
21215-0036			15. Decedent's Edu		MM TT	edent's Usual Occup	ation		16h Kind	Whi of Business/In		
15	within 72 ho piene. r than "natui	Completed	(Specify only highest grad	e completed)	(Giv	e kind of work done of DO NOT use retired	during most of v	vorking	100.11.110			
12	within the control of	E	Elementary/Secondary (0-12)	College (1-4o		uck Drive	r		Δııto	omotive	Indus	tru
	it the	Ö	17. Father's Name (First, Middle, Last)		44	dek biivei		ame (First, Middle, I			TIMES	шу
an	Q 2 0 0	To B	Ferdinand Fruhlin	na			Kathe	erine Kuro	wski			
Maryland	s 1 and 2 should be if Health and Mental Itam 27 is marked oother treumatic eve	1-	19a. Informant's Name/Relationship (T)	_	19b. Mai	ling Address (Street		Rural Route Number		own, State, Zip	Code)	l l
S	nd 2 illth ar 27 is r treu		Cheryl Fruhling	(daughte	r) 915	Pine Road	TOTA	a, Maryla	nd	21085		
ē,	s 1 an I Heal Itam 2		20a. Method of Disposition	Tadagnee	20b. Place of Disc		11/24			ion - City or To	own, State	
Baltimore,	ages ant of it: #1		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		A ''		' (06/2006	Ralt:	more	Marula	nd
=	permit. Pag Department Important: any Injury c		21. Signature of Euneral Service Licens					F. Lassah				
Ba	permit. Pages 1 Department of H Important: If Ita any Injury or ot once.		774	. 01				- Kingsvi			•	
- 63			23a, Part1. Enter the disease, or comp	lications that caus	ed the death. Do not en					race y ra	Approximate	е
	*		shock, or heart failure. List only o	ne cause on each	line.	CARC	1.100	1			Onset and D	
1	Physician /Medical		disease or condition resulting in death)	a. Sup to for a	is a consequence of):	CALC	INOVI	77			5 MON	743
2	Examiner			Due 10 (01 E	a a consequence or,							
45.1	. # 1%	e.	5 aquartially list conditions if any, leading to immediate	b Due to (or a	is a consequence of):							
1	uted d ansit	듵	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d								
9	ifficate I g physi as the b	ed			-							
Box	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					230	I. Date of delive	ery	
	death e atte	lc la	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant		□Ectopic pregnancy □ Other (specify) _	/			Month	Day Y	rear .
P.0	t the de by the a	Physician/Me	9 🗆 Unknown	9□ Unknown								
	es tha igned be del	by P	Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of d	eath?
Ę	w require been sig should b	Pa	CARCONIC M	MELO,	SENOUS	LEUK	emia	1 U Y	es 2 🗆 !	No 3 Prot	ably 4 □U	Jnknown
S	s bee	let						24a. Was a		4b. Were auto	psy findings a	available
Re	: The law cate has t page 2 s	Completed						- autops perfore 1 ☐ Yes	med?	death?	mpletion of ca 2□ No	AUSO OI
tal	ician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of D	eath (Check only or	1	1 🗆 103	2010	
of Vital Records,	Physician: r this certifica ral director, I	To B	examiner?	Hospital:	tient 2 ER/Outpatie	ent 3 DOA Oth	OF.	Home 5 Reside		Other (Specif	(v)	
0	o Phi ter thi		27. Manner of Death	28a. Date of Ir (Month, L	jury 28b. Time	of 28c. Injur	y at	28d. Describe h	ow injury o	ccurred	···	
ion	nding l th. r: After e funer	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORTH, L	Day Year) Injury		Yes 2 □ No					
Division	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	njury - At home, farm, s	treet, factory, office		28f. Location (S. City or Town		lumber or Rura	al Route Num	ber,
	el or s effe s Dir ed in	Certification:	4 Ditomolds	building,	etc. (Specify)			Oily or Tour	i, Siale)			
	To the Hospitel or Attending within 24 hours effer death. To the Funarel Director: After completely filled in by the fune				st of my knowledge, dea							
	n 24 he Fu	Medical	one) 2 Medical Exam	and manner	of examination and/or i stated.	rivestigation, in my o	pinion, death of	correctat the time, d	ate and pl	ace, and due to	une cause(s	1
	To the To the Comp	Σ	29b. Signature and title of confifier	- 1	- 120 N	29c. Licens	e number	2	9d. Date	igned (Month,	Day, Year)	~/
	11		177 dh	nor	- VVJ	1	3///	2 F	EBR	MARY	-d,d	000
	かか		30. Name and address of person who c	ompleted cause o	death (Item 23a) (Type	. Print) 2117	- BEL	AR R	0792	U	14	
	0		IN TOWAR	25 M	7.	FAUST	UN. V	MRYLA	NI	21	ot /	
	Sta Regist		31. Date filed (Month, Day, Year) FFB 1 0 200	Se. Regi	strar's Signature	sier de	L	U			ı	

FRUHLING, SR

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day, **Physician** 2006 February 9:45 a Robert Preston Ferry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Hill Harford 1706 Samantha Drive 8. Date of Birth Nov. 17, 1922 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F Director 217-18-9708 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-1 show If itam 27 is marked other than "natural", or Items 23a or 28a-1 shov or other traumatic avent, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Forest Hill Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21050 1706 Samantha Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "nat any nijury or other traumatic avent, I're Medica once." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) insurance insurance agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katharine Preston Dr. Bernard J. Ferry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5628 Williams Road, Hydes, Md. 21082 19a. Informant's Name/Relationship (Type, Print) John H. Ferry/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/2006 Baltimore, Md. New Cathedral Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA **Physician** 2 MINVIES /Medical Due to (or as a consequence of): Examiner ORDN ARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEROSCLEROSIS burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Yes 2 No 3 Probably 1 Unknown Completed CARDIAC CONGESTIVE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1. SNatural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on one) 29b. Signature and title of contilier 29d. Date signed (Month, Day, Year) RAMANAGOPALAN MD. 30 Pame and address of pereon who completed cause of death (Item 223) (Type Print)

KAMANA (ANPALAN MD) ZE ROLLING (ROSS ROADS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		•	For State Registrar	State of Ma	ryland		rtment of F			giene No. ()	06	03807
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ıth	.,	3. Time of Death
н	Physicia		MARIE		FI	ELI	5		Month FEBRUAR	Day ン ひぎ	200 C	1230 M
}	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)				r Location of Dea	th	4c. Cou	nty of Death)
			JOHNS HOPKINS	SBAYVIEU	U HOSE	NAL	BAL	TIMOR	25			
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	Year)	Cou	place (State or Foreign intry)
	Director		213-05-0940	M 2XIF	92	Yrs.		110010	6/21/1	913	M	laryland
	and w		Usuel Residence of Decedent 10a, State 10b, County		10c. City	Town or Loc	ation					10d. Inside City Limits
	laho	5	MD Baltimo	ore	,	rlea						1 □ Yes 2√JNo
	the A	ect	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	
	with the control	Funeral Director	4810 Kenwood Aver	1116			21206	,			5.A.	, .
	ns 23	era		12. Was Decedent E	ver in U.S.	13. W	as Decedent of F	lispanic Origin? (5	Specify Yes or No-		Race - Amer	ican Indian,
' O	ritter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		If	Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		Black, White	, etc.
ဗ္ဗ	al', o	þ	3 🔀 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐Yes 2∑xtNo	Specify:		Spe	cify: Wh	ite
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation		16a. Decede	ent's Usual Occup	ation	ndking	16b. Kind of	f Business/i	ndustry
7	en e	nple l	Elementary/Secondary (0-12)	College (1-4or 5-	+)			during most of wo d)	g			
2	ygien yerth t, the	S	7			Hous	ewife				Home	
Maryland	be fill ital H id oth	Be	17. Father's Name (First, Middle, Last) Andrew Pilarski						me (First, Middle,		name)	
$\frac{2}{3}$	i Men varke	မ							ann Wagn			
a	l 2 sh ang r i ia m		19a. Informant's Name/Relationship (Ty	•					ural Route Numbe			
e)	is 1 and 2 of Health ar item 27 is other treu		Pat Gajewski/Niece		20b. Plac				Baltimo	re, Ma	-	
٥	ages if it		1 \$ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	1		ition (Name of atory or other place		3/06		•	
Baltimore,	it. Partment	i	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	20	Gai		of Faith		•			Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: of them 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature of voltage service Electrist						Baltimor			Home Inc. 21206
			23a. Part1. Enter the disease, or somelishock, or heart failure. List only or	eations that caused ne cause on each line	the death. e.	Do not ente	r the mode of dyir	ng, such as cardia	c or respiratory are	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	14400	TEN.	Sior	V					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):						
	LAGITITIE		Sequentially list conditions,				IC STE	ENOSIS				YEARS
+	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i conseque	nce or):						
	and and II-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a	1 conseque	nce of);						
8760,	ficate be executed physician and s the burial-transit	aiE				·						
687	ficate physics the	edicai									n)	
	eath certifi attending for use as	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of						23d.	Date of deliv	very
Box	that the death cer ed by the attendin detached for use	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1☐Live birth 2 4☐Pregnant at t			Ectopic pregnancy Other (specify)	/			Month	Day Year
<u>о</u>	t the d by the lached	hys	9 Unknown	9□ Unknown								
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions cor	tributing to death bu	it not resulti	ng in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use c	antribule to	the cause of death?
Ĕ	w require been sign	pe							1 🗆 Y	es 2□No	3 🗆 Pro	bably 4 DUnknown
ပ္ထ	e law re has be ge 2 sh	Completed							24a. Was a	an 24	b. Were aut	opsy findings available ompletion of cause of
<u> </u>		PO.							perfor	med? 2 No	death? 1 ☐ Yes	
ita Vita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						ath (Check only or	ne)		
\leq	Physic this c	은	TES ZIMINO	lospital: 1 🔀 Inpatier		VOutpatient		4 Li Nursing I	Home 5 Resid			ıfy)
Ē	Jing P	e E	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	Bb. Time of Injury	28c. Injur		28d. Describe h	ow injury occ	curred	
Sic	ttend death ctor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	On Blace of Init	a. Athom			Yes 2 □ No	296 Lanation (C	Man - 4		- L Clark Market
Division of Vital Records,	s efter s efter si Direct sd in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	e, rann, sire	et, ractory, office		City or Tow		mber or nu	ral Route Number,
	To the Hospitel or Attending Phwithin 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifying Physical Control Check only one)	sician: To the best oner: On the basis of and manner state	examination	edge, death n and/or inve	occurred at the tie	me, date and plac opinion, death occ	e, and due to the durred at the time, o	ause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	1 11		7	29c. Licens	se number	2	29d. Date sig	ned (Month	, Day, Year)
			histing &	offiner	-M.	D.	P19	626		Feer of	TRY!	5. 2006
	3		30. Name and address of person who co		eath (Item 2	3a) (Type, F	rint)					,
)		CHRISTINA S. HIN			10 Et	STERN	AVENUE	BALTIN	nore	ms	21224
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	K A	gode?					
	11091011		FFR 1 (1 /	THIN EXMAN	ASC. 0 .5	W PR						

Certificate of	Death Reg. N	ło.	
Contificate	Dooth		200
State of Maryland / Department of H	lealth and Mental Hygien	menna n38	8 N S
		•	

Physician /Medica Examine For

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ODGs.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

Registrar		Certif	icate of D	eath (Reg.	No.						
1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death					
Robert	Gooch				February		11:30 A M					
4a. Facility Name (If not institution, give s	treet and number)	41	. City, Town, or	Location of Deat	h	4c. County of Death						
University of Maryl 5. Social Security Number 6. Sex			Baltim Under 1 Year	ore If Under 24 Hrs	9. Date of Birth	N/A	lane (Christa au Fausian					
	(M 2□F 4	M	onths Days	Hours Min.		1958 9. Birtin	place (State or Foreign htry) HI					
10a. State 10b. County	10c. Ci	ty, Town or Location	on				0d. Inside City Limits					
Maryland Anne Art				Burnie			1 □Yes 2 ☑No					
369 Dublin Drive		1	10f. Zip Code	21060	10g	Citizen of What Coul USA	ntry?					
11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of His is, specify Cuban Yes 2 1 No	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.					
15. Decedent's Educ	ation	16a. Decedent	's Usual Occupat	tion	161	b. Kind of Business/In	dustry					
(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	1	d of work done di NOT use retired) ICKING	uring most of wo	rking	Warehous						
17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Mai	iden Sumame)						
Robert Barnet				Mary		cinovich						
19a. Informant's Name/Relationship (Type, Print) Martha R. Gooch (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 369 Dublin Drive, Glen Burnie, MD 21060												
20a. Method of Disposition	20b. F	Place of Dispositio	n (Name of		Date 200	c. Location - City or To	own, State					
20a. Method of Disposition 1												
21. Signatur of Funeral ervi	2				Stallings F Pasadena	Funeral Ho , MD 21122	na P.A.					
shock, or heart tailure. List only on Immediate Cause (Final disease or condition resulting in death)	Carbon Monox	cide Into	vicatio	n		noev	Interval Between Onset and Death					
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a conseq	uence of):		COUNT APP	ONED BY MEDICAL EX							
that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):	C	ERTHICATION								
_ d												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 □Ect	opic pregnancy ner (specify)			23d. Date of delive Month	ery Day Year					
Part II. Other significent conditions con	tributing to death but not res	ulting in the under	Vind cause one	in Part I	23e Did tobac	co use contribute to the	ne cause of death?					
	moduling to doubt out not rea		lying cause given		1 ☐ Yes		37					
					24a. Was an autopsy performed 1 Yes 2X	prior to co	psy findings available impletion of cause of					
25. Was case referred to medical				00.01 10		No 1 ☐ Yes	ZLI NO					
examiner? 1 M Yes 2 □ No		ER/Outpatient 3	B DOA Other	4 Nursing H	ath (Check only one) fome 5 Residence	e 6 □Other (Specif	γ)					
27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury For Month, Day Year) 02-02-2006	Fourith Fourith 9:56 A	28c. Injury Work?	at es 2.1XINo	Subject inhaled truck exhaust fumes.							
3X Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street.	factory, office		281. Location (Stree City or Town, S		Poute Number berton Dri					
29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occition and/or investi	curred at the time igation, in my opi	e, date and place nion, death occu	, and due to the caus	e(s) and manner as s	tated. the cause(s)					
29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)					
1/11/-			Andres	112 - 0		_						
20 Normand addition	No sayor	FF	407176	1000	16701 F	E13 05	2006					

State Registrar

GRAHAM SNYDER

31. Date filed (Month, Day, Year)

32. Registrar's Signature

22 S. Greene Street, Baltimore, Maryland 21201

Administrator

20b. Place of Disposition (Name of cametery, crematory or other place)

A M

Education

20c. Location - City or Town, State

February 6, 2006

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Whitehead

8600 Burning Tree Road, Bethesda, Maryland 20817

Date

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Funera δ Completed Be

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Harvey Arthur

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Kenneth F. Gordon / Husband

College (1-4or 5+)

5+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Frederick P. Smith, M.D.

0

31. Date filed (Month, Day, Year)

deeth with the Maryland if itam 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic avant, the Modical Examinar must be notified at

Baltimore, Maryland 21215-0036

Funeral

Director

Physician /Medical **Examiner**

ending physicien and use as the burial-transit Box 68760 Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached:

	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Montgomery (,		Februa 2006	ary 9,	tho	sda, M	[arv] a	ad.
	21. Signature of Funeral Service Licens	mot	M01305 Roll 755	pert A. 7 Wisc	Pumphre onsin Av	y Funera enue, Be	1 Home/Be	thes aryl	da-Chev and 208	y Chase 14 – 3501	, Inc.
	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused to the cause on each line	ne death. Do not ente	or the mode	of dying, such	as cardiac or	respiratory arres			Approxin Interval 8 Onset ar	Between
	Immediate Cause (Final disease or condition	a Endometr	ial Cance	r						1 Yea	ar
	resulting in death)	Due to (or as a	consequence of):								
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inflated events	b. Due to (or as a	consequence of):								
ical Exa	resulting in death) Last Due to (or as a consequence of): d										
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pre Other (spe				230	d. Date of del Month	livery Day	Year
ed by PI	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	derlying ca	use given in Pa	art I.	23e. Did toba 1 ☐ Yes			the cause of	
Complet							24a. Was an autopsy performe	d?	24b. Were au prior to death?	utopsy finding completion of	s available cause of
Be (25. Was case referred to medical examiner?				26. Pla	ace of Death ((Check only one)				
	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	3 DOA	Other: 4	Nursing Home	e 5 🕅 Residenc	e 6[☐Other (Spe	cify)	
Medical Certification: To	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		niury 28b Time of 28c Injury at 28d Describe how injury occurred						occurred		
Certific	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - Al home, farm, stre (Specify)	eet, factory,	office	28	Bf. Location (Stre City or Town,	et and l State)	Vumber or Re	ural Route N	umber,
edicai	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of iner: On the basis of e and hanner state	xamination and/or inv	occurred a estigation, i	t the time, date n my opinion, o	and place, and death occurred	nd due to the cau d at the time, date	se(s) ar	nd manner as lace, and due	s stated. to the caus	9(s)
ž	29b. Signature and title of contrib	•//	1//	29c.	License numbe	er	290	. Date :	signed (Mont	h, Day, Year)

D0033293

5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

DHMH 17 Rev 1/2001

State

Registrar

	1	For State Registrar			Ce	rtifica	ate of	Death	1		Reg. N	. UU	D	U381U	_
ysician		1. Decedent's Name <i>(First, Middl</i> e, Last, Evory Darnell Gi								2. Date of D Month	eath Da		Year	3. Time of Death	
lical	ŀ	la. Facility Name (If not institution, give		-}		4h Ci	ty, Town, o	r I ocation	of Death	Feb	4	20 c. County o	006	3:10 p M	
miner	j	Joseph Ritchie				8a]	timo	re							
al or	2	710-04-0037		ge (In yrs.	/ast birthday)	Month	der 1 Year Is Days	If Under Hours	Min.	8. Date of B	irth 66 , 0 – 5 ()	9. Birth	place (State or Foreign ntry)	
_		Usual Residence of Decedent 10a. State 10b. County MD			ty, Town or Lo									10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
i Director	5	10e. Street and Number 923 Chinquapin	Pkwy				Zip Code 2123	9				itizen of Wh	nat Cou		
by Funeral		11. Marital Status N_Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tes 2 Fi If Yes, Give 2 Year or Dates	? No	1		cedent of H pecify Cuba 2XXIIo	lispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	lo-		, White,		
Completed		15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or	5+)		kind of DO NOT	work done i use retired	ation during mo: 1)	st of worki	ng		Kind of Bus		dustry	
Be Co	(D)	17. Father's Name (First, Middle, Last)	19yr	S	Nur	sin	g		er's Name	(First, Middl		spit n Sumame,	the an		-
any injury or other traumatic event, the Wangade. To Be Comple	_	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailii	ng Addre	ss (Street			/ Route Num.	ber, City	or Town, S	tate, Zip	Code)	
	-	Clare Jefferson 20a. Method of Disposition		20b. F	5923 Place of Dispo	sition (A	lame of	1		y Bal		MD .ocation - C			_
	-	1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Sa	cred	Hea	rt			-06 ley C					
once		> Marken	Mar	A						. Nal				21231	
an al er	Т	23a. Pard En the disease, o compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ca ions that caus- ne cause on each. A C 4 U1Y Due th (or a	d In	juence of):	or the m	ode of dyin	g, such as	dro m	r respiratory	arrest,			Approximate Interval Between Onset and Death	
cal Examiner	1	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseq										18, years	
Physician/Medical		IF FFMALE:	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	it death 3	Ectopic	pregnancy (specify)					23d. Date Monti		ery Day Year	
P P	Т	Part II. Other significant conditions col	tributing to death	but not res	ulting in the u	nderlying	cause givi	en in Part	l.		tobacco Yes 2			he cause of death?	
v 🔼										24a. Wa auto pen 1 ☐ Yes	opsy ormed?	pri	or to co ath?	psy findings available mpletion of cause of 2 □ No	
director, page fo Be Com	1	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	lospital:		FD(0-1		Oth			Check only		. ===			
<u>res</u>	1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		28b. Time of Injury		28c. Injun Worl	4(3/N	2	ne 5 Res 28d. Describe				(y)	
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ledical C		29a. Certifier 12 Certifying Physical (Check only one)	nician: To the best ner: On the basis and manner s	of examina	owledge, death	occurre estigati	ed at the timon, in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the	cause(s	and manr d place, an	ner as s d due to	tated. the cause(s)	
dwoo W		29b. Signature and title of certifier					9c. License							Day, Year)	
) Swelliam B	enedict.	ms			D00	४५८	3		7	15/0	6		_
State		30. Name and address of person who co 31. Date filed (Month, Day, Year) FFB 1 0 20	enidict mpleted cause of DKT 15 32 Regist	rar's Signa	ture	1921	£ 5T.	, (Buti	かのとし	mo	2/2/	7-		-

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			1 - For State Registrar		State	ot Ma	aryland		artment of I rtificate of			Mental H	ygien Reg: N	IIIIh	1	03811
			1. Decedent's Name	e (First, Middle, La	st)							2. Date of D	eath		ear	3. Time of Death
	hysici/ Medio/		Ernest									02	0.8		6	3.45 AM
	Examir	ner	4a. Facility Name (If	_			0170	,	4b. City, Town,					c. County of		
			5. Social Security No	SAMARI umber 6.5			PITA	1_ ast birthday)	BALT)		der 24 Hrs.	8. Date of B	irth	BALT,	Righ	nlace (State or Foreign
	uneral rector		586-60-0		X M 2□F		75	Yrs.	Months Days	Hou	rs Min.	Feb. 6	Dav. Year	31 T	hu	ippines
pur	3		Usual Residence of 10a. State	Decedent 10b. County			10c City	, Town or Lo	ocation							10d. Inside City Limits
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the	r 28a-	Directo	10e. Street and Nun						10f. Zip Code				10g. C	itizen of Wh	at Cou	ntry?
th witl	23a o		2864 La	ke Avenu	e					212	13		u.	.S.A.		
1213-UU30 within 72 hours after deeth with the Maryland ane.	al', or iteme 23a or 28a-f show Exsoliter must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2∏XMarried	12. Was Dec Armed F 1 [AYes If Yes, G Year or I	orces?			Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 ☒ No			pecify Yes or No Rican, etc.)	lo-	14. Race - Black, Specify:	White,	etc.
2 hou 2	'natural', dical Exs	ted !		15. Decedent's E	ducation			16a. Dece	dent's Usual Occu	pation			16b.	Kind of Busir	ness/Ir	dustry
1 21 5-0036 ithin 72 hours af ₁₈ .	Med "n	Completed	(Special Special ify only highest grand ndary (0-12)	ade <i>completed,</i> College ((1-4or 5	+)		kind of work done DO NOT use retire		nost of won	king	n.	. a C+a	6.0		
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Yland Z Suld be filed Mental Hygid	ted of	To Be	Mariano								cadia			n Sumame)		
Shout nd Me	mari	ř	19a. Informant's Na	ame/Relationship (Туре, Print)			19b. Mailir	ng Address (Street					or Town, Sta	ate, Zij	Code)
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Saltimore, bermit, Pages 1 er Department of Hee	or other		20a. Method of Disp 1 X Burial 2	oosition Cremation 3	Removal from	State	l ce	metery, crei	osition (Name of matory or other pla	ice)	1	Date		Location - Ci	-	
ICIM it. Pa rtmen	ortent: injury o			5 Other (Special	_		Sac		eart of.							
perm Depa	21. Signature of for ral Society of Pacifity Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236															
			23a. Part1. Enter th	ne disease, or com	plications that	caused	the death.									Approximate Interval Between
, Phy:	sician		Immediate Cause (Final		_	DIAC	A	RREST						114	Onset and Death
	edical miner		resulting in death)	(Due to	(or as	a consequ	ence of):		n 1 n 1						· 3
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uted	dansit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	rtying injury	. a	RC	NAA	ey i	ARTER Y	1	DISE	ASE.				Yerms
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	physic the b	dica			d										-	
Geath certificate	attending physic for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, ou	utcome	of pregnan	ncy						23d. Date of	f deliv	erv
	e atte	sicia	in the past 12 1 ☐ Yes 2 ☐	months?		nant at	2 Fetal time of de		⊒Ectopic pregnand ☐ Other (specify) _	У				Month		Day Year
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Hecords, P.O.	signed b	þ	Part II. Other significant	ER TENS		beath b	ut not resu	king in the d	nderlying cause gr	ven in F	art I.		Yes 2		∏ Prol	,
S v	should b	iete										24a. Wa	s an	24b. We	re auto	posv findings available
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	rtifica stor, p	BeC	25. Was case refer	red to medical						26. P	lace of Dea	th (Check only		0 1	105	2 140
OT VITA Physicien:	this ce al direc	ဥ	examiner?			Inpatie		ER/Outpatier	nt 3□ DOA Ot	her: 4	Nursing H	ome 5 🗆 Res			(Speci	fy)
on o		Certification;	27. Manner of Death 1 Natural	5 Pending		of Injui nth, Day	Year)	28b. Time o Injury	Wo	ryat nk?]Yes 2	P.□No	28d. Describe	how inj	ury occurred		
UIVISION I or Attending etter death.	octor: by the	fica	2 Accident 3 Suicide	investigation 6 Could not be determined	e 28e. Plac	e of Inju	ury - At hor	me, farm, str	reet, factory, office			28f. Location	(Street a	ind Number	or Rur	al Route Number,
S effer	el Director: A ed in by the fu	Certi	4 🗍 Homicide	dotottimiod	build	ding, etc	. (Specify))				City or To	own, Sta	te)		
DIVISION To the Hospitel or Attending within 24 hours effer death.	To the Funeral I		29a. Certifier (Check only	1 Certifying Pi	nysician: To th	e best	of my know	vledge, deat	h occurred at the ti vestigation, in my	ime, date	and place,	and due to the	e cause(s) and mann	er as s	tated.
the h	mplete	Medical	one) 29b. Signature and		and mai	nner sta	ited.		29c, Licen					ate signed (/		
F. i¥	28	-	250. Signature and	title of certifier	dumar				RES					2/08	4	
1.	XI		30. Name and addre	ess of person who		use of d	eath (Item	23a) (Type, 2123	Print) VIKR			IAR, 5				WEN BLUD.
	Sta	ate	31. Date filed (Mont					-								
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DHMH 16 Rev 6/95

Registrar

0 2006

Amend item#5, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Roberta Harrison 2006 2028 Feb 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Maryland Medical Center N/A40 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 25 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 ☑ F Yrs. MD Director 78 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 'natural', or items 23a 7766 Overhill Road filed within 72 hours after death the Hygiene. Also then then matural; or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien-fimportant: if item 27 is marked other the any injury or other traumatic event the Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Calvert Aleathea Denton Asher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7766 Overhill Road, Glen Burnie, MD 21060 (spouse) Thomas R. Harrison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03 Feb. Metro Crematory Inc. Baltimore, Maryland 4 □ Donaţion 5 □ Other (Specify) 2006 22. Name and Address of Facility 21. Signature Funeral Swice Lice See Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> Part1. Enter the disease, or complications that clused the shock, or heart failure. List only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myeloid **Physician** eukemia Acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ettending physician and for use as the burial-transit Box 68760. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. cete hes been signed by the case page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 achalasia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 21 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nopatient 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred at or Attending P safter death.
I Director: After id in by the funera After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a Cartifier Cartifying Physician: To the best of my knowledge, death commed at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ua Dame, MD P17678 Teb 2,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia Blome Street Baltimore, MD 21201 225. Greene 31. Date filed (Month, Day, Year) FEB 1 0 2006 32 Registrar's Signature State Registrar

			For State Registrar	State of Maryla		partment of F ertificate of			4	006	03814
	*		Decedent's Name (First, Middle, La				304177	2. Date of Dea			3. Time of Death
	Physici /Medic		JAMES	HEI	ER			Februo	Day	Year 2006	7:30 PM
3	Examin Funeral Director	er	4a. Facility Name (If not institution, given the policy of	YVIEW MEDIC.	. last birthda	ay) If Under 1 Year Months Days	T Location of Death T M O R If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb4,	BA	Coui	lace (State or Foreign
	D .		Usual Residence of Decedent	10-0	. T.						
	anylar •hov	Į.	MD Balt	imore	ity, Town or Esse						0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the h	rect	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cour	
	h with	0	354 Montrose	Ave.		21221			USA		ŕ
21215-0036	be filed within 72 hours after deeth with the Maryland tial Hygiene. Id other than "naturel", or items 23e or 28e-f ehow event, I're Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	J.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	}	Race - Americ Black, White, pecify: Wh	etc.
2-0	72 ho	sted	15. Decedent's E		16a. De	cedent's Usual Occup	ation during most of works	na	16b. Kind	of Business/In	dustry
12	within 900.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work done s. DO NOT use retired aftsman	d)				Security
Q 2	e filed within al Hygiene. I other than ' vent, tre Me	ပ္သို	17. Father's Name (First, Middle, Last,	1+		ar coman	18. Mother's Name	e (First, Middle,		gency	
an	should be id Mental marked o	To Be	Marshall Heie	r			Margar	et Roe	sler		
Maryland	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Туре, Print)	19b. Ma	ailing Address (Street	and Number or Rura	al Route Numbe	er, City or To	own, State, Zip	Code)
	and 2 ealth m 27 I		Linda R. Heier		- Intrakaning to	54 Montro sposition (Name of		_			1221
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe ODGS.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	1 / 0 6	Balt	ion-City or To	MD				
Ball	permit Depart Impor eny in		21. Signature of Funeral Service Licer	alHomo	eofEssex 221						
			23a. Part1. Enter the disease, or communication shock, or heart failure. List only	plications that caused the dea	Do not	enter the mode of dyir	ng, such as cardiac c	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pleural	Eff	nsion					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of);						
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a contre	quenne of):						
B	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
38760, 2	cate be executed physicien end the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
876	ate br	dlcal		d.							
P.O. Box 6	death certifi e ettending ad for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	el death	3 □Ectopic pregnancy 5 □ Other (specify) _	1		23d	I. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	<u>ک</u>	Part II. Other significant conditions of	0 . 0	sulting in the		ren in Part I.			contribute to the	ne cause of death?
Division of Vital Records,	S S	Completed	0					24a. Was autop perfor 1 Yes	an 2 osy rmed? 2 No	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		tiont 30 DOA Oth	26. Place of Death				
of	Phys r this ral dir	5	1 ☐ Yes 2 ②No 27. Manner of Death	28a. Date of Injury	28b. Time	III JUDA	4 Nuising Ho	me 5 Resid			y)
lon	ding th: Afte	itlor	1 Alatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injur	y Wor	rk? Yes 2 □No				
Divisi	al or Atter s efter dea d Director d in by the	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At building, etc. (Spec	home, farm,	street, factory, office		28f. Location (S City or Tox	Street and N vn, State)	lumber or Rura	I Route Number,
	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kn niner: On the basis of examin and manner stated.	lowledge, de lation and/or	eath occurred at the tir r investigation, in my o	me, date and place, a ppinion, death occurr	and due to the deed at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	1		29c. Licens				igned (Month,	
	. ^		Fright In	L,MD		RE	5-000		Februa	iry 8	,2006
	Y /		30. Name and address of person who	completed cause of death (Ite	ASTE	De, Print) RN AVE	NULE BA				1224
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	FRN AVE		. (1)	fast		

			1 - For State Registrar	State of Marylan		ent of Health and ate of Death		iene 19. No. 0 0 6	03815
÷	Physici	an	1. Decedent's Name (First, Middle, Las	HOFFMAN			2. Date of Deat Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		4b. 0	City, Town, or Location of De		4c. County of Dea	7
		9	UNIVERSITY OF ME			BALTIMOR			
\$.	Funeral Director		5. Social Security Number 6. Security Number 11 315 - 54 - 0950 11 Usual Residence of Decedent	7. Age (In yrs.	Yrs. Mon	nder 1 Year If Under 24 H			thplace (State or Foreign ountry)
	nyland how		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	8a-1 e	Funeral Director	mo Battim	ore (8m			1 Tyes 20 No
	with the	Dir	10e. Street and Number	0	10f	. Zip Code	10	0g. Citizen of What C	ountry?
	ma 23	nera	12074 Glen AP	12. Was Decedent Ever in U	.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Am	
98	72 hours after death with the Maryland natural, or Hema 23a or 28a-f ehow Jeal Exemiraet must be neillisd at	by Fu	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 ⊠No If Yes, Give		specify Cuban, Mexican, Pu	eno rican, etc.)	Black, Whi	te, etc.
215-0036	tural'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's	Usual Occupation		16b. Kind of Business	Uhite Andustry
215	within 72 ene. than "ne the Medic	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give kind o	f work done during most of v T use retired)	vorking		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
2	filed withi Hygiene. other than	Con	12	4	Self E	mployed -N	1erchant	Maple Hill	Farm Market
Maryland	ould be fit Mental H Marked off Matic ever	o Be	17. Father's Name (First, Middle, Last)	Hoca					
ary	2 should and Men is marks sumatic	P L	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Add	ress (Street and Number or	Rural Route Number,	City or Town, State	Zip Code)
	12 a		Mancy Carol Hoff	nan-spouse	12074	Sten ARM ROO	d, Glen Ar	marylo	ind 21057
altimore,	8° = 5		20a. Method of Disposition 1 ZBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory	or other place)			
Itim	Department Department Important: any injury		4 □Donation 5 □ Other (Specify 21. Signature of Peral Service Licen.	Tain	Ty Enscar	a CH-CEM Feb e and Address of Facility E	11, 2006	Long GR	een, Maryland
Ba	permit. It Departm Importar any injur		VIST 40 18	les -	88(Y)	Hastord Road	Vans Chape	nrouled	naries DI234
Ď.	*3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat					Approximate Interval Between
fize.	Physician		Immediate Cause (Final disease or condition	a MULT	IPLE m	IELOMA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):				
V	acuted and transit	Examiner	that initiated events	C					
8760,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of);				
687	ficate phys	edic	`	d					
Вох	death certifica attending ph d for use as th	M/us	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		ic pregnancy		23d. Date of de	
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐Unknown				Month	Day Year
P.0	res that the de igned by the a be detached t		Part II. Other significant conditions co	ontributing to death but not res	ulting in the underly	ng cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	w requires been sign should be	ed by					_ 1 □ Y€	s 2 Z No 3□P	robably 4 Unknown
eco	e law requ has been je 2 shouli	Completed			····		24a. Was a	v prior to	utopsy findings available completion of cause of
_							perform 1 Tes 2		s 2□No
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3	Othor	Death (Check only on	e) ence 6 □Other (Spe	
o o		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		w injury occurred	эспу)
sior	eath. or: Af the fur	catic	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 ☐ Yes 2 ☐ No			
Division	or Ati Biter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fa fy)	ctory, office	28f. Location (St City or Town	reet and Number or F n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina	owledge, death occu	rred at the time, date and plation, in my opinion, death or	ace, and due to the ca	ause(s) and manner a	s stated.
	thin 24 thin 24 the F	Medi	29b. Signature and title of certifier	and manner stated.		29c. License number		9d. Date signed (Mon	` '
	<u> </u>		* Flore	MD		D 00621	}	2 9 06	
	h		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Print)				
	")		MOHANETUMA	AUT 225:0	GREENE	STREET IBI	ALTIMORE	IND.	
¥.	Sta Regist		MOHAN ETUMA 31. Date filed (Month, Day, Year) FEB 1 0 2000	Hegistrar's Signa	ature Coule				

			For State Registrar	tate of Mar	yland / Depa <i>Ce</i>	artment of		and Mei		ene	6 0	3816
	Physici	an	Decedent's Name (First, Middle, Last)	_				-	Date of Death Month	Day	Year	3. Time of Death
	/Medic Examir	al	Clifton Worth Ho 4a. Facility Name (If not institution, give street 2608 Pin Oak Ro	t and number)		4b. City, Town, Edgew			ebrua	4c. County		
	Funeral Director		5. Social Security Number 6. Sex 1238:-14-5265		(In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days		Min	Date of Birth (Month, Day, OV • 1	Year) , 1914	Counti	ace (State or Foreign ry) h Carolina
	with the Maryland is or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford	1	10c. City, Town or Lo						10	d. Inside City Limits
	with the sa or 28 lbe ro	Director	10e. Street and Number 2608 Pin Oak Road			10f. Zip Code 21(140		10	g. Citizen of W		ry?
980	72 hours after death w natural', or items 23a Jeal Exembratmest	by Funeral	11. Marital Status 1 Never Married 25 Married	Vas Decedent Ev Armed Forces? ☐ Yes 2 No f Yes, Give rear or Dates:		Was Decedent of If Yes, specify Cut	Hispanic Original ban, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		- America k, White, e	
Maryland 21215-0036	S	Completed	15. Decedent's Educatic (Specify only highest grade co Elementary/Secondary (0-12)	n πpleted) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of working		6b. Kind of Bu		ustry
yland	should be filed with ind Mental Hygiene i marked other tha umatic event, the the	To Be C	17. Father's Name (First, Middle, Last) William Walter Hol	man			18. Mothe		irst, Middle, M	aiden Sumam aham		
Mar	od 2 sho ith and 27 is ma		19a. Informant's Name/Relationship (Type, Virgie M. Holman / W	•		ng Address <i>(Stree</i> Pin Oak						
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 Is marked any Injury or other traumatic @ <u>once</u> .		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	2	Oc. Location - Bel Air	City or Tov	vn, State
Baltii	permit. P Departm Importar any injur		21. Signature of Fundal Service Licensee	ext J	Ž.	Name and Addr	ess of Facilit	I Home	, P.A.			_
8760, 🛠	Physician //Medical Examiner physician and physician and the prijal-transit	20a. Method of Disposition Sequentially list conditions resulting in death) Sequentially list conditions resulting in death) Sequentially list conditions resulting in death) Due to (or as a consequence of): 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 22 Name and Address of Facility McComas Funeral Home, P. 1317 Cokesbury Road, Abut 1317 Coke									-	Approximate Interval Between Onset and Peath Onset Application
.O. Box 68	ne death certific the attending p hed for use as	by Physician/Med	in the past 12 months?	f yes, outcome of □ Live birth 2 □ Pregnant at tir □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date Mor	e of deliver	y Day Year
Δ.	w requires that the been signed by should be detact	ed by Ph	Part II. Other significant conditions contrib	uting to death but	not resulting in the w		Pulm	onery	1 ☐ Yes		ibute to the	cause of death?
Vital Records,		Completed		remia	stoid (arthn	di	nolk.	24a. Was an autopsy perform	ed? d	Vere autoportion to come eath?	sy findings available ipletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ital:	• 🗆 = = = = = = = = = = = = = = = = = =				heck only one)		
Division of	or Attending Physician: after death. Director: After this cartific in by the funeral director,	Certification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day)	/ear) 28b. Time o	f 28c. Inju		nce 6 ⊡Othe winjury occurre				
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certifi	4 Homicide determined 2		y - At home, farm, st (Specify)				City or Town,	State)		Route Number,
	he Hospital in 24 hours a he Funeral I pletely filled	Medical	29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	n: To the best of a On the basis of ea and manner state	xamination and/or in	h occurred at the t vestigation, in my	time, date an opinion, dea	d place, and th occurred	due to the ca at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
	To the within 2 To the complet	₹	29b. Signature and title of certifier Nove	22 A	Brig		se number	, -		d. Date signed		
	12		30. Name and address of person who comple	eted cause of dea	MD	Print) Ole G	311	2 N	10 =	2107	8	
	Sta Regist		31. Date filed (Month, Day, Year) FFB 1 0 2006	32. Registrar	s Signature	(h)						

Withon Worth Holman

		ı	For State Registrar	State of Marylar	•	ent of Hea		, ,	ene 9.4006	03817
***	Dhysici		Decedent's Name (First, Middle, La.	st)			2	. Date of Death		3. Time of Death
	Physici /Medio		CARLENE ELIZABET					Februar	Y 8 200	
	Examin	er	4a. Facility Name (If not institution, giv	. 1 0	4b. C	01	cation of Death	0.64	4c. County of Dea	ath
~	Funeral		5. Social Security Number 6. S			der 1 Year If		Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign
すたりい	Director		422-48-4640	□M 2 □ F 67	Yrs. Mont	hs Days I	Hours Min. M.	(Month, Day, arch 24	, 1938 AL	rthplace <i>(State or Foreig</i> n oun <i>try)</i> ABAMA
	pug *	4	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location					10d. Inside City Limits
Ĵ	Maryland -f show lied at	tor				LTIMORE	,			1 X Yes 2 □ No
Š	r 28a	irec	MD 10e. Street and Number			Zip Code		10	g. Citizen of What C	ountry?
Arlene	death with the ms 23a or 28a rms 25a or 28a	Funeral Director	1520 E. 33rd St.			2121	.8	ט	.S.A.	
4	ar dea	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was De	ecedent of Hispa specify Cuban, f	anic Origin? (Speci Mexican, Puerto Ri	ty Yes or No- can, etc.)	14. Race - Am Black, Whi	
936	hours after death with the Marylar tural; or Items 23e or 28e-1 show at Exactical must be rediffed at	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 X No ff Yes, Give Year or Dates:	1 □ Ye	s 2🖾 No 3	Specify:		Specify:	BLACK
215-0036	"natural",	ted	15. Decedent's Ed	ducation	16a. Decedent's U	Isual Occupatio	n	1	6b. Kind of Business	
275	_ 36	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)			ng most of working			
727	be filed withing that Hygiene. Id other than event, than H		12 17. Father's Name (First, Middle, Last)	2	Director		S & Recr		Recreat:	ion
and	should be filed nd Mental Hygi marked other imatic event, i) Be		'			NNIE L.		alden Sumame)	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	s 1 and 2 should b Health and Meni tem 27 is marked other traumatic	٦ و	BURL CURRY 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr				City or Town, State,	Zip Code)
N N	and 2 alth a 27 is		JOHN W. HENRY/HUS	SBAND	1520 E.	33rd. S	st. Balti	more, M	D 21218	
School Known	t Pages 1 and 2 riment of Health s rient: If Item 27 I. jury or other tra		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □		Place of Disposition (cometery, crematory)	Name of or other place)	Dar	e 2	0c. Location - City or	Town, Sfate
は真	Pag ment ment mnt;		4 □ Donation 5 □ Other (Specific		rrison For			6 0	WINGS MIL	LS, MD
Ball	permit Pag Department Importent: any injury o		21. Signature of Funeral Service Licer	P /	Willi		Brown Com		ral Home	P.A.
.03			23a/ Part1. Enter the disease, or cop	plications that caused the deal			h_Ave. B			Approximate
	Physician		shock, or heart failure. List offy findediate Cause (Final	one cause on each line.				,	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consec						39627
	Examiner		Sequentially list conditions		stronal	tumor	s of A	Boonly		Tream
λ	ed sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
4	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):					
760,	ate be e sysicien he buri	ical E		d.						
89	The law requires that the death certificate ten has been signed by the attending phys bage 2 should be detached for use as the last tending bage 2 should be detached for use as the last tending bage 2 should be detached for use as the last tending bage 2.	ed .	IF FEMALE:							
Вох	eath certifical attending phy I for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta	al death 3 ⊟Ectopi	c pregnancy			23d. Date of de Month	Day Year
o.	it the de by the a tached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	death 5 Other	(specify)				
٦.	es that the igned by be detact	by Ph	Part If. Other significant conditions of	contributing to death but not res	sulting in the underlyin	ig cause given i	n Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	w requires been sign should be	ed b	Deep ven T	monbosis				1 ☐ Yes	s 2 □ No 3 □ P	robably 4 III nown
တ္ခ မ	e law re has be je 2 sho	Completed	Worterson.	Amia				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ĕ,		Com	,					perform	ed?death?	s 210 No
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death	Check only one	<u> </u>	
to	Phys rthis rat dii	<u>۲</u>	1 Yes 2 No	1 Depatient 2	ER/Outpatient 3 28b. Time of				nce 6 Other (Spe wintury occurred	ecify)
on :	gr eff a	tion	1 □ Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes	2 No	y. 20001100 1101	vinjary occarred	
Vis.	r Attendition of the formula of the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fac	tory, office	28	f. Location (Str. City or Town,	eet and Number or R	tural Route Number,
ِ ۵	ital or irs aft ral Dir led in									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	red at the time, tion, in my opini	date and place, an on, death occurred	d due to the car at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	A	7	29c. License nu	umber	29	d. Date signed (Mon	th, Day, Year)
			1/2:0	ale		Des-	000		ELUN - V	8 2006
	4		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	7	0			7 - 000
-			31. Date filed (Month, Day, Year)		ngi Host	pital	d- Ber	timore	EDUANY	
	Sta Registr	- 1	FEB 1 0 2006	32. Registrar's Signa	agests!					

			For State Registrar	State of M	aryland /		rtment of H		and M		giene Reg. No	UUD	03818
	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of De. Month	Day		
	/Medic		Lois Eileen				41. Cit. T		10	Februa		2006 County of Dea	1:00 A M
	Examin	er	4a. Facility Name (If not institution, give st Gilchrist Center	reet and number,)		4b. City, Town, or Tows or		or Death		46.	Baltim	
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. last b	irthday)	If Under 1 Year	If Under		8. Date of Bin	th		rthplace (State or Foreign
	Director		294-12-6891	M 200 F	82	Yrs.	Months Days	Hours	Min.	8. Date of Bin (Month, Da Aug. 7	, 19	23 Peni	rsýlvania
_	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City. Toy	wn or Lo	cation						10d. Inside City Limits
	daryla f ehor	٥	Maryland Baltimor	0			ltimore						1 Yes 2 No
	the h	rect	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C	country?
	after death with the Maryland or iteme 23e or 28e-f show refraet must be notified at	ai D	5 Ratna Court					2123	6			U.S.A	
	eme	iner	11. Marital Status	2. Was Decedent Armed Forces 1 Pes 2	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh	
36	s afte	y F.	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 If Yes, Give Year or Dates:	No		1/	Specify:				Specify:	White
Ş	filed within 72 hours after Hygiene. ither than "naturel", or fte ent, the Medical Examina	Completed by Funeral Director	15. Decedent's Educa	ation	168	a. Deced	ent's Usual Occupa	ition			16b. K	ind of Busines	s/Industry
215	hin 73	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or	5+)		kind of work done d OO NOT use retired)	uring mos	t of worki		Howl	Land To	wnships
21	ed wil	Соп	12th Grade			Воо	kkeeper				Scho		
land	uid be fil fental H rked oth	To Be	17. Father's Name (First, Middle, Last) Leo Volk							de Mil		Sumame)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than eny injury or other traumatic event, the Magnee.		19a. Informant's Name/Relationship (Type Mrs. Nancy Hayes-G				g Address (Street a						
ē,	s 1 an f Heal ftem 2		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place	1		Date		ocation - City o	
e E	Pages tent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 💢 Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	9 !	•	l Cemete		2/8/	2006	Vier	ına, Oh	io
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service Licenses			9	Name and Addres	s of Facili	Sch. B	imunek altimor	Fune	ral Ho ND 212	mes 36
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that cause	d the death. Do								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Lun	a	Cance	R					Months
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence	of:							
		er	Sequentially list conditions, b.	Due to (or as	s a consequence	v of):							
~ 1k	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
30	ate be executed hysicien and the burial-transit	Exe	resulting in death) Last	Due to (or as	s a consequence	of):							
0) (0)		dicai	d.					_			_		
) ×	ath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome								23d. Date of d	elivery
OB	death e atter d for u	iciar	in the past 12 months?	4 Pregnant a	2 ☐ Fetal deat at time of death		Ectopic pregnancy Other (specify)					Month	Day Year
00	at the de by the a tached	hys	9 □ Unknown	9□ Unknown								****	
ds, t	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions cont	ributing to death	but not resulting	in the ur	nderlying cause give	n in Part I		23e. Did t			to the cause of death? Probably 4 DUnknown
	aw requir is been si 2 should	Completed								24a. Was		24b. Were	autopsy findings available
. Be	0 5 2	E O								autoj perfo 1 ☐ Yes	psy rmed? 2 2 No	death?	completion of cause of
1 D S S S S S S S S S S S S S S S S S S													
75	Phys this al dii	၉	1 □ Yes 200 No	spital:		_	The second secon	4 🗆 N		me 5 ☐ Resi		6 XOther (Sp	ecity) to spice
ુપુ	ding After fune	tion	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inj (Month, D.	ay Year)	Time of Injury	Work	ai (? /es 2.∐		28d. Describe	now inju	ry occurred	
isi	Attend r death octor: A	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At home,	farm, str	eet, factory, office		-				Rural Route Number.
2 <u>6</u>	ital or irs after ral Dire	Certification:	4 Hornicide		atc."(Specify)					City or To			
7	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one)	cian. To the bes er: On the basis and manner s	of examination a	ge, deair ind/or inv	r occurred at the till restigation, in my op	ie, date ai pinion, dea	id place, ath occurr	ed at the time,	date and	d place, and di	ue to the cause(s)
	To the Within To the comp	×	29b. Signature and title of ceptilier	any V	2len	u	29c. License	number	25		29d. Da	te signed (Moi	inth, Day, Year)
	6		30. Name and address of person who con	nple of duse of	death (Jem 27a	(Туре, 5 7 d	Print) N- a	har	les_	St. Bo	ela	4. md	21206
	Sta Registi		34. Date filed (Month, Day, Year) FEB 1 0 20	67	trar's Signature								
	riegisti	ш	FEB 1 0 20	UO A									

			Please	State of Mar				Mental Hygie	•	22210
			For State Registrar	Olato of Mai		rtificate of		Reg.	ZHHD	03819
	Dhysisi	on.	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death	Day Year	3. Time of Death
1	Physici /Medio		Willie Mas	Harron				February	300s F	
4	Examin	er	4a. Facility Name (If not institution, give		G (1)	4b. City, Town,	or Location of Dea	th	♣c. County of Deati	1
	Funeral		5. Social Security Number 6. S.		In yrs. last birthday	If Under 1 Year		8. Date of Birth	9. Birth	nplace (State or Foreign
	Funeral Director				87 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Ye 12 25	18 Co	nplace (State or Foreign untry) NC
	pu .		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or L	conting				10d. Inside City Limits
	Aarylan I show ed all	ō		'	Baltim					1 XYes 2 No
	or 28a-f	Director	MD NA 10e. Street and Number		Daitim	10f. Zip Code		10g.	Citizen of What Co	untry?
	h with	<u>I</u>	3829 Park Heig	hts Ave 2	nd floo	r 2:	1215		U.S.A.	
	ams 2	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of I	Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer Black, White	
36	or it	y Fu	1 Never Married 2 Married	1 □ Yes X□ No If Yes, Give		1 ☐ Yes XX No				lack
21215-0036	within 72 hours after death with the Maryland ane. than "natural, or itams 23e or 28e-f show ita Madical Examiner must be notified at	Completed by Funeral	Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	edent's Usual Occu	nation	161	b. Kind of Business/I	
215	nin 72 nn "na Madik	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Giv	e kind of work done DO NOT use retire	during most of wo	orking		
21	filed with Hygiene. other than	Com	L2th grade	na		Domest	ic		Privat	e
nd	should be filed within Mental Hygiene. marked other than matic evant, the Mental Menta	Be	17. Father's Name (First, Middle, Last)	_				me (First, Middle, Mai		
Maryland	should be nd Mental marked o	2	William Edmond 19a. Informant's Name/Relationship (1)		10h Mail	ing Address (Street	1	Jane Smi		in Code)
Ma	Par a					 Box 2. 		altimore,		217
ē,	s 1 and of Health itam 27 othar tr		Otis Knight-So 20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla			. Location - City or	
E C	Pages nent of int: If its iry or o		1 Burial 2 □ Cremation 3 □ '4 □ Ponation 5 □ Other (Specify	Removal from State				2/14/06 H	Pikesvil	le, Md
Baltimore,	permit. Pages Department of the important: If its any injury or or once.		21. Skinsture of Funeral Service Licen		2	arch F/	ess of Facility	12		
	207 29		e firme to	Shimps	4	300 Wab	<u>ash Ave</u>	, Baltimo		21215
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.						Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediat Cause (Final disease or condition resulting in death)	a. End	stage	Cordio	mopat	~~		
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Ţ		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
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760,	be executed iician and buriat-transit	i Ex	resulting in death) Last	Due to (or as a	consequence of):					
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d						
Box 6	certifi nding use at	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	very
	death e atte	icia	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		□Ectopic pregnanc □ Other <i>(specify)</i> _	ey		Month	Day Year
P.0	at the by the	hys	9 □Unknown	9□ Unknown						
	w requires that been signed to should be deta	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause gr	ven in Part I.		co use contribute to	
ord	requi	eted					-			
Records,	has t	Completed						24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical			<u></u>	26 Place of De	ath (Check only one)	No 1 □ Yes	2 No
≥		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	har	Home 5 Residence	e 6 Other (Spec	infy)
0 1	ding Phys	:uc	27. Manner of Drath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time Injury	of 28c. Inju	ork?	28d. Describe how i	injury occurred	
Sio	Attanding ir death. actor: After by the fune	catio	Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □No	001 1		
Division of	or At after d Diract in by	Certification;	4 Homicide determined	28e. Place of Injury building, etc.		treet, factory, office		City or Town, S	at and Number or Ru State)	rai Houte Number,
_	spital ours narai filled	ai C	29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, dea	th occurred at the ti	ime, date and plac	e, and due to the caus	se(s) and manner as	stated.
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam	niner: On the basis of e and manner state	xamination and/or i	nvestigation, in my	opinion, death occ	urred at the time, date	and place, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month	n, Day, Year)
•	_		1/4/1			Q at	00594	23 J	Ebruan	182004
	\mathcal{V}		30. Na d Mas person who	completed cause of dea	ath (Item 23a) (Type	() Print)	1 0 4	6		1 8 2004 1 8 2004
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1 03H M	4.15W6	-305 YSW	more in	(1625)
	Registi		FEB 1 0 2		M. A.	and b				
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DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar Amend Item #	State of Marylan					giene	6	03820
	4		7	Decedent's Name (First, Middle, Last)	10c,17,17aab	1111	0000	ZIJOU OH	2. Date of De	ath	V	3. Time of Death
		Physici /Medic		Ahmed	Ifteka	ar	Н	ussain	Month 02_	08 :	Year 2006	04:40 M
		Examir		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
_				Upper Chesapeak	e Med. Cent	cer	Belai	r If Under 24 Hrs.	Day of Bir	На	arfo	
		Funeral Director		5. Social Security Number 6. Sex XX	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 10 10	74	9. Birth	place (State or Foreign ntry) MD
	·2			Usual Residence of Decedent	J1				10 1	<i>J</i> / 1		
		the Maryland 28a-f ehow		10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
		Ba-f-	cto	MD Harfo	ord -	Be lai r	- Bel	AIr				1 ☐ Yes 2 ☒ No
		ih th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
		death with		935 Jackson Blyd				1014			S.A.	
2		ltem Item	Funerai	11. Marital Status 1 1 □ Never Married 2 □ Married	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No 	S. 13. W	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)	Bla	ck, White,	can Indian, etc.
3	336	lrs at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 🎇 No	Specify:		Specif	y: A	sian
ofto an	ŏ	within 72 hours atter ane. than "naturel", or Ite na Madical Examina	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decede	ent's Usual Occur	nation during most of work	trin a	16b. Kind of B		
7	21	thin .	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	d) _	n i g	Ameri	can	Home
7	21	ygien ygien t, ner th		12th grade	4yrs	Loar	Speci			Mortg		
S	Maryland 21215-0036	i 2 should be filed w n and Mental Hygie i e marked other ti reumatic event, ID	Be	17. Father's Name (First, Middle, Last) Mohammed Hussain				18. Mother's Nam			ne)	
	ž	d Mei mark matic	2	Mohammad Haccalf 19a. Informant's Name/Relationship (Typ		19h Mailing	Address (Street	Mubash			State Zi	Code)
P	Ma	d 2 sith an treui		Mohammed Hussain/				200.48 St 9	Bel Air			
00/8	ē,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If them 23 or 28-1 ehow them 27 is marked other than "naturel", or Iteme 23 or 28-1 ehow other treum the routilisal at		Mohammad Huggalf 20a. Method of Disposition	20b. P	lace of Dispos	lackson		Belair Date	Md 2. 20c. Location		
8	9	Pages ent of nt: If It		Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movai from State		atory or other pla	Park 2/	10/06	Panda	11c+	own. Md
7	Baltimore	permit. Pages Department of Important: If It eny Injury or o		2) Signature of Funeral Service License			Name and Addre		10/00	Nanda	IISC	Own, na
0	m	Depa Impo eny I		Etterne A. Si	humpan	43	300 Wab	ash Ave	, Balt	imore,	Md	21215
	er.	11.5		23a. Part1. Enter the disease, or complice slock, or heart failure. List only on	cations that caused the death	n. Do not ente	r the mode of dyl	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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		/Medical		resulting in death)	Due to (or as a consequ							10.37
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	V	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):						
3	_	and and il-tran	хап	that initiated events c.	Due to (or as a consequ	uence of):					-	
53	8760	cate be executed physicien and the burial-transit	dicai E		·	•					1	
S	687		edic									
##	ŏ	Se 14: 08:	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		F-4:-			23d. Da	ite of deliv	ery
	m.	0 0	icia	in the past 12 months?	4 Pregnant at time of di		Ectopic pregnanc Other (specify) _	у		M	onth	Day Year
7	P.0	that the de ed by the detached	ly S	9 🗆 Unknown		Can .			-thyte			
Ahmed			ğ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the un	derlying cause gr	ven in Part I.				the cause of death?
2	Records,	w requires been sign should be	Completed	NONE	·········				10	Yes 2 → No	3 [] Pro	bably 4 □Unknown
X	ec	e 2 sl	npie						24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
-	_	: The lay icete has ; page 2							1 ☐ Yes	ormed? 2 100	death?	2 (3 No
Ĵ	Vital	Physician: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	_	Ott	26. Place of Dea				
WSS-EI	o	Phys r this ral di	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 □ Inpatient 2 ☑	ER/Outpatient 28b. Time of	3 LOOK	4 🗀 Mursing Fi	ome 5 Resi	dence 6 Oti how injury occur		fy)
55	O	tending Ph death. tor: Atter th the funeral	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 ☐ No		,2.,		
3	Division	200>	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, stre	et, factory, office				ber or Rur	al Route Number,
I	ā	P Pig	Certification:	4 Homicide	building, etc. (Specify	y)			City or To	wn, State)		
		To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno ier: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the ti estigation, in my	ime, date and place opinion, death occu	, and due to the tred at the time,	cause(s) and m date and place,	anner as	stated. to the cause(s)
		To the P within 2- To the P complete	Me	29b. Signarure and title of certifier			29c. Licen:	se number		29d. Date signe		
		- > - 0		Me Atte	nding		1.	1644	,	Hlora	nan	18 th 2006
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	-	1.0		VIJAY.S. NAIRA				BELAI	RMD	210	14	0
	-		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		1 ===					
	119	Regist	rar	FEB 1 0 2	IIII Alam	K A	aged &					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Dorothy Marie Hampson February 6, 2006 4:00 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3100 N. Ridge Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF Months Days Hours Yrs. Director 213-20-0824 92 Sept.21,1913 | Maryland Usual Residence of Decedent Worle ns 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 21 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 N. Ridge Road 21043 USA death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status The Mudical Exercities J filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. ģ 3 XWidowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than *ns any injury or other traumatic event, Ita Medic 2006. (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Hutzler's 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James P. Mulhern Marie L. Sauerland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 12123 Carroll Mill Court; Ellicott City, MD 21042 Barbara A. Boglitsch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2/10/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²². Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Foreral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Havanced of ementic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 TNo Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital r: After this certification and funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification or Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0063681 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Road Gen Burnie 15 Loesle Kurup 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 1 0 2006

DHMH 17 Rev 1/2001

ORIGINAL

CPM 06-00976 Evelyn Hostetler Unpend item#23a,PIL.27,28a I pend L. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.- UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Evelyn Hostetler February 07, 2006 15:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 25, 1946 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🕱 F 59 Yrs. 218 44 7124 July Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itame 23s or 28s-f show the Madical Examiner must be nutitied at 1 ☐ Yes 2 No Middle River Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 1108 Orems Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental important: if item 27 is marked of any injury or other traumatic ever 9068. Esther Wheeling Fleener Hamby 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 Orems Rd. Baltimore, Maryland 21220 Frederick Alan Hostetler Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other pla Gardens Of Faith 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. Horm 1407 Old Eastern Avenue Essex, Md. 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acetaminophen intoxication complicating fatty liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 cal Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown cete hes been sig , page 2 should b Hypertension; Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1,23 Yes 2 \(\times \) No 24a, Was an autopsy performed? certificate 1 Yes 2□ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XXYes 2 ☐ No 1 XInpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending After 5 Pending investigation 1 Natural 1 ☐ Yes 2X No Fnd 2/7/2006 Fnd 2:58 P 2 Accident after death the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1108 Orems Rd. Middle River, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide To the Hospital within 24 hours a To the Funeral C Find at residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Tymedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 08, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MUC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

	1 - For State Registrar	State of Maryland /	Certificate of			ene 006	03823		
Physician	1. Decedent's Name (First, Middle, Last)	UETI ED			2. Date of Death Month	Day Year	3. Time of Death		
/Medical Examiner	a me and the contract of the c	4b. City, Town, o	or Location of Death	2	2 2006 4c. County of Death	12:00 A ^M			
	Atlantic General		Berlin			Worcester			
Funeral Director	5. Social Security Number 274-10-0894 Usual Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/25/1	9. Birth Cou	place (State or Foreign intry) OH		
yland	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits		
r 28a-f ehow	MD Worcest	er Bei	rlin				1 X Yes 2 No		
itier death with the Mar r Iteme 23a or 28a-fel uner must be notified	10e. Street and Number	212 6 11 6	10f. Zip Code		10	g. Citizen of What Cou	intry?		
iteme 23	1 Meadow St. Apt	12. Was Decedent Ever in U.S.	eek 2181 13. Was Decedent of H If Yes, specify Cub		ecify Yes or No-	USA 14. Race - Amer			
" O = -	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗓 No		Rican, etc.)	Specify: W	, etc. hite		
permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mental Hygiene. Important: if Item 27 le marked other then "neturel", eny Injury or other traumatic event, the Maddal Exaginds.	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	ia. Decedent's Usual Occup (Give kind of work done	during most of worki	ng 1	6b. Kind of Business/I	ndustry		
iene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesman	a)		Insuranc	~ <u>~</u>		
be filed tal Hyg d other event,	17. Father's Name (First, Middle, Last)		Jajesillati	18. Mother's Name	(First, Middle, M		JC		
J Ment J Ment J Ment Jarked Jarked J Ment J	Levi Elmer Hetle	r		Mary	May Ru	ıby			
and 2 sh ealth and n 27 le n	19a. Informant's Name/Relationship (Type) Pauline M. Hetle	P 15	9b. Mailing Address (Street 1 Meadow St						
of Heal	20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other pla	1 0		Oc. Location - City or T			
Pages ment of ant: If It ury or o	1 Donation 5 ☐ Other (Specify)	emoval from State	sfield Cemete	ery 2/6/	2006	Mansfield,	OH		
Departit. Departit Import eny inj once.	21. Signature of Funeral Service License		22. Name and Addre	ess of Facility Th	e Burba	ge Funera	I Home		
	23a. Part1. Enter the disease or complic	cations that caused the death. D		am St., B ng, such as cardiac o			Approximate		
Physician	shock, or heart failure. List only on Immediate Cause (Final disease or condition	GASTNOENTE	RITIS				Interval Between Onset and Death		
/Medical Examiner	resulting in death)	Due to (or as a consequence					160 444		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
executed in and ial-transit	that initiated events C.								
icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):							
tificate being physicial as the bur	d								
eath certifi attending for use as		23b. Was decedent pregnant 2.5c. il yes, outcome or pregnancy					23d. Date of delivery		
by the attertached for	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)	,		Month	Day Year		
res that the death cerigoned by the attendin be detached for use by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute						the cause of death?		
w requires been sign should be	NONE				1 □ Yes	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
: The law requir	24a. Was an autopsy pr						Were autopsy findings available prior to completion of cause of		
certificate harector, page	performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No								
hystcian: his certific il director,	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 □ ER/0	Outpatient 3□ DOA Oth	26. Place of Death) nce 6 □Other (Spec	(fv)		
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ttendii death. tor: A the fu	2 Accident investigation 3 Suicide 6 Could not be	39 o Diago of Injury. At home	M 1 Tes 2 No		19f Logation /Stre	41			
tal or Attending F rs after death. al Director: After led in by the funers Certification:	4 Homicide determined	building, etc. (Specify)	t home, farm, street, factory, office 28f. Location City or T			_(Street and Number or Rural Route Number, Town, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examin	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
othe orple	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
F 3 F 0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAZAAIC ENIOLA 9733 Health way Drive Bettin My Atlant					2/2/0	Ь		
	30. Name and address of person who con	mpleted cause of death (Item 23a	() (Type, Print)	D(0)	settin n	91) 111. 1	010 112		
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			_ For	State of Maryla	and / Dep	artment of H	lealth and I	-	_	ible.	03821
			1 - State Registrar		<i>Ce</i>	rtificate of	Death		g. No.		00069
	Physici	an .	Decedent's Name (First, Middle, La					2. Date of Deat Month	Day	Year	3. Time of Death
	/Media		GEORGE WASHINGTON HYDE					Februar	4	2006	1:05 P ^M
	Examir	ner	4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death	1	4c. Count		
			PRESBYTERIAN HO			Tows					County
	Funeral		5. Social Security Number 6. S	CH OFF	rs. last birthday, ``Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,			plece (State or Foreign ntry)
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(1215-UU36 within 72 hours after death with the Maryland ene. than "natural; or Items 23e or 28e-1 show	and	-	10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits
	Mary	ō	Maryland Baltimor	ra County		Towson					1 ☐ Yes 2 No
	289 100 III	Director	10e. Street and Number	e county		10f. Zip Code		11	Og. Citizen of	What Cour	ntry?
	3a or	0	400 Georgia Cour	• t-			21204		US	ι Δ	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Ra	ce - Americ	
0	riter	Ē	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give 1 □ T.T.T.T.				o Rican, etc.)				
5	al', o	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII 1 Yes 2 ₽			1 ∐ Yes 2 No	2X No Specify:			Specify: White	
Z15-0036 thin 72 hours af e. an "natural", or	72 ho	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup e kind of work done	ation	rkina	16b. Kind of E	Business/In	dustry
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N	be filed within 72 ho tal Hygiene. d other than "natu event, the Modical		12		Sale	es Manage				Serv	ices
and	be file		17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, M	Maiden Sumai	me)	
<u>z</u>			Dudley	Hyde	,			e Antoine			,
Mar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (ing Address (Street			-		
	s 1 and if Health item 27 other tr		J. Thomas Hyde	(Son)		2 Meredith	n's Ford				
ore			20a. Method of Disposition 1 X Burial 2 Cremation 3	(o. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. Location	- City or To	own, State
Ě	permit. Pages Department of Importent: If it any injury or o		`4 □Donation 5 □Other (Special	(y) W	est Riv	er Quaker	Cen 2/9	/2006 (Calesvi	He.	Maryland
saltimore,	Depart Depart Import sny inj once.		21. Signatury of Funeral Service Lies	nsee Waran	2	2. Name and Addre	ss of Facility	Funaral	Home	Tnc	8
<u>"</u>	70 E # 9		Martin D. Law	son		5500 York	Road. Be	iltimore.	Mary 7	and 2	1212 Aproximate
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Examiner	Examiner		Sequentially list conditions.	b							
7	ν π	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury								
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χ Ω	death certificate be executed e attending physician and nd for use as the burial-transil	dical		_ d							
χ Q	leath certificate attending phy: I for use as the	Physician/Med!	IF FEMALE:	220 If you outcome of pro-	202001				1		
XOR	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year		
- -	at the de by the a stached f	sic	1 ☐ Yes 2 A No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify) _					
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II a	Physician: Th this certificate ral director, pag		25. Was case referred to medical examiner?	11				th (Check only one	3)		
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ट ह	tel or Attending PI s after death. el Director: After ti ed in by the funera		27. Manner of Death 1 DNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer	28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Injury Work?			28d. Describe how injury occurred			
DIVISION	or Attending ster death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No							
≥	or At fter d pirect in by	E	4 Homicide determined	286. Place of injury - A	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	urs a		20- 0	1							
	Host 24 ho Fune tely fi	lica	(Check only 2 Medical Exe	ny sician: To the best of my l miner: On the basis of exam							
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one) 29h Signature and title of certifier	and manner stated.		29c Licens	e number	20	d Date signs	ed (Month	Dav. Yearl
	T With		29b. Signature and title of certifier			mn in				d. Date signed (Month, Day, Year)	
					Attending mo 037016			February 7, 2006			
	1-		30. Name and address of person who		tem 23a) (Type	, Print)					
	(g		Kenneth M. Gree	ne, 6701 Nort	h Charl	es Street	, Towson	, Maryla	nd 2120)4	
	Sta Registr		on sate mod (moral, say, 1 od/)	GE. Megistral 3 Si	£	A					

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AR 7:45 AM M 006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 08/27/1955 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 ☑ F 50 577-78-3444 Yrs Director MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at Director MD Howard 1 ☐ Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4524 Rusty Gate Items 23a 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced 'neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be John S. Denton Helen M. Harten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Deguzman 4525 Rusty Gate Ellicott City, MD 21043 other t 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 10 ` 4 ☐ Donation " 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2006 Beltsville, Maryland 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee Wille MO1443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Chronic of Aructive plymonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Tinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death Check only one) examiner' 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To this 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a filled 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) teb, DX 7006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMOR 500 BACTIMORE 31. Date filed (Month, Day, Year) State FEB 1 0 2006 Registrar

_			1 - For State of Maryland / I	Department of Health and Certificate of Death	Mental Hygier	. U U D	03826
	Physic /Medi		1. Decedent's Name (First, Middle, Last) ORVA LEE JOHN S		repulary	Bit 2001	3. Time of Death 2.00A M
1	Exami	ner	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL	4b. City, Town, or Location of Deat BALTIMORE	E	tc. County of Dea BALTIMOR	E CITY
	Funeral Director		5. Social Security Number 234-16-0485 Usual Residence of Decedent	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Bir	thplace (State or Foreign ountry) Va.
	anyland show	_	10a. State 10b. County 10c. City, Tow				10d. Inside City Limits
	the Ma 28e-f	ecto	Maryland Baltimore City 10e. Street and Number	Baltimore City			1 X Yes 2 □ No
	th with 23e or	al Di	3714 Pinewood Avenue	2120	6	Citizen of What Co	ountry?
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumatic event, the Medical Examiner must be restlifted at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	ithin 72 ha ne. nen "netu	npleted	(Specify only nignest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)		Kind of Business	
nd 21	be filed w lal Hygier d other th	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	dministra on Sumame)	ation
Maryland	should id Men marke matic	T _O	Rex Fraley 19a. Informant's Name/Relationship (Type, Print) 19b		Childers		
	and 2 s alth an 127 is er treu			. Mailing Address <i>(Street and Number or Ru</i> 3801 E. Northern Parl	_{irai Route Number, City} kway Baltim	or Town, State, 2 nore, Md.	Zip Code) . 21206
Baltimore,	ages 1 ag		X Burial 2 ☐ Cremation 3 ☐ Removal from State cemeter	Disposition (Name of ry, crematory or other place) Vood Cemetery 2-16		Location - City or	
Baltii	permit. Pages 1 a Department of Hes Importent: If item eny injury or othe once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lassahn Funera	740)l Belaiı	
			23a. Parti. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one oduse on each line.	not enter the mode of dying, such as cardiac		to., Md.	Approximate
	Pnysician /Medical	i Pi	Immediate Cause (Final disease or condition resulting in death)				Interval Between Onset and Death
	Examiner		Due to (or as a consequence of	of): July 1000	ident-		3 weeks.
/-	ed sit	iner	Sequentially list conditions, a day, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Th.			
oʻ	cate be executed physician and the burial-transit	Examiner	that initiated events c	nf):			
8760,	icate be physici s the bu	dlcal	d				
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 1 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
Δ.	Se un e	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	w require been sig should b				1 ☐ Yes 2	!□No 3□Pro	bably 4 Unknown
	The lar ate has page 2	e Completed	OF Western day of the state of		24a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of 2000 No
f Vital	di S	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) Hospital: 1 \(\text{No} \) 1 \(\text{No} \)		th (Check only one) ome 5 - Residence	6 □Other (Spec	ifu)
on of	ding Ph h. After th funeral			ime of 28c. Injury at jury Work?	28d. Describe how inju		
Division	or Atten ifter deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No m, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rui e)	ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical Ce	29a. Certifier (Check only one) Medical Exeminer: On the basis of my knowledge, and manner stated and manner stated.	death occurred at the time, date and place,	and due to the cause(s) and manner as	stated.
	To the vithin 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d Da	te signed (Month	Day Vone
)			Much Imperiali	Type. Print) Baltimore.	Febr	nary 8	Th 2006.
	10		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) Ballimore	16d-2	1239	7.
Υİ	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 0 2006 Registrar's Signature	porti			

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>		of Health a		Reg. No. 00	6 03827
	Physici	ian	Decedent's Name (First, Middle, Last, Glenn Edward	Johnson	14			2. Date of De	Day	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give			4h City Tow	vn, or Location o	Februa	ry 7, 200	
	Examir	ner	509 Cider Press (Јорра	Dodan	1	rford
	Funeral Director		5. Social Security Number 6. Sec	7.	Age (In yrs. last birthday) 58 Yrs.	If Under 1 Y		Min. Aug. 8. Date of Bit (Month, Date of Bit (rth 29. 1947	9. Birthplace (State or Foreign Country) Mass.
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	٥	Md. Harford			Јорра				1 ☐ Yes 2 ☐ No
	r 28e	irec	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of W	hat Country?
	th with	ai D	509 Cider Press (Ct., Apt	. E		21085		U.S.	Α.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel', or Iteme 23e or 28e-f show any Injury or other treumatic event, the Medical Erain Let mail be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 🖄 Yes 2 [If Yes, Give Year or Date:	□No	Was Decedent If Yes, specify (gin? (Specify Yes or No , Puerto Rican, etc.)	5- 14. Race Black Specify:	- American Indian, , White, etc. white
2-0	72 hou	sted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Oc	ccupation one during most	of working	16b. Kind of Bus	iness/Industry
21215-0036	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+) life.	DO NOT use re	etired)			nt.,
2	Hygier Hygier Ther th		12 years 17. Father's Name (First, Middle, Last)		recnn	cai ac	count ma	anager r's Name (First, Middle	l	nty company
lan(ld be ental l ked o ic eve	To Be	Elmer Johnson					ria Scicca		,
Maryland	od 2 shou of the and M 27 is mar	F	19a. Informant's Name/Relationship (Ty Donelle Moore/fri					r or Rural Route Numb Ct., Joppa,		
Baltimore,	Pages 1 and the part of Hear of Item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from Sta	20b. Place of Dispo cemetery, crea Arlington	natory or other	place)	Date 2/14/2006	20c. Location - C	on, Va.
Balti	permit. Departri Importe any Inju		21. Signature of Funeral Service Cisens	90				ral Home of L Road, Bel		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or		ed the death. Do not ent					Approximate Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death)	col.	on canc	er				2.5 years
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):					
	F34 1	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of):					
	cate be executed bhysician and the burial-transit	Examiner	cause. Enter Underlying Cause United Expension that initiated events							
o,	ate be executed hysician and the burial-transit	Exe	resulting in death) Last		as a consequence of):					
8760,	ate by	dicai		1						
D. Box 6	aath certifi attending I for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 Fetal death 3 at time of death 5	Ectopic pregna Other (specify			23d. Date Mont	
P.O.	thet the de ed by the detached		Part II. Dther significant conditions cor	ntributing to death	but not resulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
ds,	uires the signed I Id be det	d by						10	Yes 2□No 3	Probably 4 Munknown
Records,	The law requii ate has been s page 2 should	Completed							psy pri prmed? de	ere autopsy findings available or to completion of cause of ath?
		0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only of		Yes 2 K No
of V	di S	To B	examiner? 1 ☐ Yes 2 ② No	lospital: 1 ☐ Inpa	itient 2 ER/Outpatier	t 3 DOA	Other: 4 Nur	sing Home 5 🖫 Resi	dence 6 □Other	(Specify)
0	ding Ph h. After th tuneral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. Time of Injury		Injury at Work?		how injury occurred	d
isio	ttendi death. tor: A	icati	2 Accident investigation 3 Suicide 6 Could not be	One Place of I	Injury - At home, form, etc		1 ☐ Yes 2 ☐ N		Street and Number	or Rural Route Number.
Division	l or Attencatter deatt after deatt Director:	Certification;	4 ☐ Homicide determined	building,	Injury - At home, farm, str etc. <i>(Specify)</i>	eet, ractory, on	ice	City or To		or nural noute Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C		ner: On the basis	st of my knowledge, death of examination and/or in stated.	vestigation, in n	ny opinion, deat	h occurred at the time.	date and place, an	d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	MI		29c. Lic	cense number		29d. Date signed	(Month, Day, Year)
) ,	1+1		Nes le	-		De	59578	302	Februara	7,2006
10	^'		30. Name and address of person who co	mpleted cause of	f death (Item 23a) (Type,	Print)	A 11			
	4		JULIS MESSESSMIH, 31. Date filed (Month, Day, Year)	MD 40	Strar's Signature	oadway	Balt	more Mary	(me) 21	231
	Sta Registr		FFB 1 0 200	06	f death (Item 23a) (Type, North Bristrar's Signature	sik)				

			_ For	i icasc i	State of Ma	aryland	d / Depa				Mental Hy	giene		22220	
			- State Registrar 1. Decedent's Name (First	Middle Last	1)		Cei	rtificate o	of Dea	th	2. Date of De	Reg. No.	JO	3. Time of Death	_
16	Physici /Media		HER B	BERT	- JA	FCR	SON				Month	Day	2006	12:31 AM	
1	Examir	1	4a. Facility Name (If not in		street and number)	acn,	TAL	4b. City, Tow	n, or Locati	on of Death		4c. Cou	nty of Death	Į	
	Funeral		5. Social Security Number	6. Se			ast birthday) 3 Yrs.	If Under 1 Ye Months Da	ear If Un	der 24 Hrs.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	lace (State or Foreign	7
1.00	Director		Usual Residence of Dece	dent	B 201						12.17.	1922		VA	
	Marylan III Show	tor	10a. State 10b.	N/A		1	, Town or Lo	ication TM TV	e				1	0d. Inside City Limits 1	
	be lited within 72 hours after death with the Maryland tall Hygiene. A property of other than "natural", or items 23s or 28s-f show event, the Marical Exam for mist be notified at	Funeral Director	10e. Street and Number 4315 Colb	ovie.	Road			10f. Zip Coo	212	29		10g. Citizen	of What Cour	ntry?	
	or death tems 2:	unera	11. Maritaf Status		12. Was Decedent Armed Forces?		S. 13.	Was Decedent f Yes, specify (of Hispanic Cuban, Mex	Origin? (Sprican, Puerto	pecify Yes or No Rican, etc.)		lace - Americ lack, White,		_
036	ours afte	þ	1 Never Married 2 3 Widowed 4 D	•	1 MYes 2 ☐ N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🛣	No Spec	cify:		Spe	cify: B	ack	
21215-0036	in 72 ho n "natu	Completed	(Specify onl	ecedent's Edu y highest grad	le completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	ne durina r	most of wor	king	16b. Kind of	Business/Inc	themical	
	filed within Hygiene.		Elementary/Secondary 17. Father's Name (First,		Colfege (1-4or 5)+)		Labor	- 1	othoda Nam	ne (First, Middle		omp	any	
	2 should be fit and Mental H is marked off aumatic even	To Be	2	CSON							Jackso		ame)		
	od 2 sho lith and 27 ts m rtraum		Avdell Tac		Wife		19b. Mailir 4315				ral Route Numb				
ore,	Pages 1 ar nent of Hea int: If Item iry or other	1	20a. Method of Disposition 1. ☑ Burial 2 ☐ Crer	n	Removal from State			sition (Name o		100.	Date 13.06		n - City or To	own, State	
	P. Lord Brit.	li	4 Donation 5 C			Mar		Name and Ac					<u> </u>	MD 21229	
8	Dep de de de de de de de de de de de de de		23a Part Enter the dise	Afort ease or comp	li ation that caused	the death	Do not ent	51 Bai-	HMO.	re N	or respiratory a	Pile 1	Batto	Approximate	
	hysician		23a. Part. Enter the dise shock, or heart faifu Immediate Cause (Finaf disease or condition	re. List only		ne. 125/			-,,		,			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):	otic (CARI	DIDVA	scule	A DI	SEACE		
. /	sit sit	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	s, ite	Due to (or as			7,00	27,7, 0	, ,			307 76		
0,	ate be executed ysician and he burial-transit	Examin	that initiated events resulting in death) Last		C. Due to (or as	a consequ	ence of):								
	icate be physici s the bu	edicai		•	d										_
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ds, P	es ing gned be de	ρ	Part ff. Other significant	conditions co	ntributing to death b	ut not resu	fting in the u	nderlying cause	given in Pa	art I.	1	obacco use co Yes 2 □ No		ne cause of death?	_
Records,	e law requir has been si je 2 should	Completed									24a. Was	osv	prior to cor	psy findings available mpletion of cause of)
		e Con	25. Was case referred to	medical					26 P	lace of Dea		ormed?	death? 1 Tes	2 🗆 No	
of Vi	rnysicion; this certific ral director,	ToB	examiner? 1 Tyes 2 No	Ī	Hospital: 1 Impatie		ER/Outpatier	I JU DON	Other: 4		ome 5∐ Resi	dence 6 🗆 🤇		γ)	
	Fe Te	ation;	27. Manner of Death 1 ☑Natural 5 ☐ 2 ☐ Accident	Pending investigation	28a. Date of Inju (Month, Da)		28b. Time of Injury		njury at Work? 1 ☐ Yes 2	2 □No	28d. Describe	now injury occ	urred		
-	is or Attendii s after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of fnet building, etc	ury - At hor c. (Specify)	me, farm, str	eet, factory, off	ice		28f. Location (City or To		mber or Rura	l Route Number,	
	Hospit 4 hour Funera tely fills	edical C			nician. To the best iner: On the basis of and manner sta	examinati									
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	8		KositA	R. (. 5	BOI	V S	ECO	URS	HOS	PITA	76	
	Sta Registr		31. Date filed (Month, Day		32. Fégistra	ar's Signati	ure	redi							

				1 - For State Registrar	State	of Maryla				leaith and Death	Mental Hy	Reg. No.	A DE	03829
	1			1. Decedent's Name (First, Middle,	Last)						2. Date of D Month	eath Day	/ Yea	3. Time of Death
		Physici /Medi		Walter			Jol	hnsor	1		02	06	200	
	-	Examir		4a. Facility Name (If not institution,	give street and no	umber)		4b. City		Location of Dea	ith		County of De	
				Good Samarit	an Ho:	spital	,	3		more		40-	-	more
		Funeral		5. Social Security Number 214–18–1252	5. Sex 1 1 M 2 □ F		s. last birthday, Yrs.		or 1 Year Days	If Under 24 Hr Hours Mir	. (Month, L	lay, Year)	9. B	Sirthplace (State or Foreign Country)
	2	Director	ļ	Usual Residence of Decedent	X	85) 113.				5-2-	20		Md.
		and w		10a. State 10b. County		10c. C	ity, Town or L	ocation						10d. Inside City Limits
		Mary feh	ō	Md.	NA		Ba	ltimo	ore					1, Yes 2 No
		vurs after death with the Manylar elf, or items 23a or 28a-f show Examinar must be notified at	Director	10e. Street and Number				-	ip Code			10g. Citi	zen of Whal	Country?
		3a or	D	1514 Gorsuch A	venue				2121	8			USA	
		items 2	Funerai	11. Marital Status		cedent Ever in	U.S. 13.	Was Dec			Specify Yes or Norto Rican, etc.)	0-		merican Indian,
	9	after or its	F	1 Never Married 2 Marrie		2 XNo		1 Yes		Specify:	into Fridain, Gro.,			Black
	5-0036	tiled within 72 hours after death with the Maryland Hygiene. sither then "naturel", or items 23a or 28a-f ehow ent. The Medical Examinat nature notitied at	d by	3 Widowed 4 □ Divorced	Year or I	Dates:								
		72 hours "natural",	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	B kind of w	ual Occupi ork done d use retired	durina most of w	orking	16b. Ki	nd of Busines	ss/Industry
1	121	within hen.	mpl	Elementary/Secondary (0-12)	College	(1-4or 5+)							G D	. oss:-
7	121	s tiled withing the Hygiene. other then		12th grade 17. Father's Name (First, Middle, L	ast)		P	'osta	l Wor		ame (First, Middl			t Office
Ö	anc	be de la	Be c	_			- 1							
N	Maryland	d 2 should be th and Mental this marked of traumatic eve	2	Clarence 19a. Informant's Name/Relationshi	p (Type, Print)		Johnson 19b. Maili		ss (Street a	Juli and Number or F	a Rural Route Num	ber, City o	Thomp r Town, State	
shhs	Ma	12 ha 7		Lenwood Johnso		Son	1				dallstow			133
,0	ā,	- I = 5		20a. Method of Disposition			Place of Disponentery, cre	osition (N	ame of	(9)	Date	20c. Lo	cation - City	or Town, Slate
7	Baltimore,	permit. Pages Department of I Important: if Its any injury or o		1. ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from ecify)	State L	oudon 1		00101 2120		11-06	Ba	ltimor	e, Md.
	alti	mit. partm porta		21. Signature of Funeral Service L	censee				and Addres	ss of Facility	Baltin			21202
	ä	Depa Impo any in		> Blad	up u	o and	1 0	March	F.H	. East			North	Ave.
				23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the dea	ath. Do not en	ter the mo	de of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
	1	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to amount of the cause. Enter Underlying Cause (Disease or injury		o (or as a conse		Fail	ure					Onset and Death
	68760, <	ficate be executed physician and is the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conse	equence of):							
	P.O. Box	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	1 Live	utcome of pregr birth 2 Pet gnant at time of nown	tal death 3[□Ectopic □ Other (:	pregnancy specify)				23d. Date of o Month	delivery Day Year
	Vital Records, P	uires that signed b	by	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	underlying	cause give	en in Part I.		tobacco u		to the cause of death? Probably 4 Unknown
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	ta	ician: Th certificate ector, pag	a	25. Was case referred to medical						26. Place of De	eath (Check only			20110
0	>	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3□ 0	Oth		Home 5 ☐ Res	-	6 □Other (Sp	pecify)
\leq	of	ding Phy h. Atter thi funeral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	of	28c. Injun Work	/ al	28d. Describe	how injur	y occurred	
	<u>io</u>	Attending Physician: or death. ector: Atter this certification in the funeral director.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investiga		nur, Day 7 Gary	III,GIY	М		Yes 2□No				
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		To the Hospital or At within 24 hours atter or To the Funeral Direct completely tilled in by	edical	29a. Certifier 1 Certifying (Check only one)		ne best of my kr basis of examin nner stated.	nowledge, deat nation and/or in	th occurre nvestigation	d at the time on, in my of	ne, date and plac pinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner place, and d	as stated. ue to the cause(s)
		To ti Withi To ti	Σ	29b. Signature and title of certifier	7.			2	9c. License	e number		29d. Dat	e signed (Mo	nth, Day, Year)
		1		bud !	pany	_ /	1.1		RES	-000)	00	2,06	, 2006
		IN		30. Name and address of person w	the completed cau		em 23a) (Type.	, Print) , Ba	ltim	week.	Manyla	nel	, 212	39
		Sta Registr		31. Date filed (Month, Day, Year)	2006	egistrar's Sigr	nature	and the	,		/			

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🕞 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EUGENE CLAGETT Jones 12:02P M February 7, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) MAY 19 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**⊠**M 2□ F 76 26 1205 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f ehow 1 Yes 2 No CARROLL MARRIOTTSVILLE mo Directo 10e. Street and Number 10g. Citizen of What Country? me 23a or 2 2105 MARRIOTTSVILLE ROAD 2/104 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status is marked other then "naturel", or iter aumatic avent, the Medical Examiner 1 X Yes 2 No If Yes, Give Year or Dates: 1951-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify à Specify: white 3 Widowed 4 Divorced 1953 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LUCENT Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN SERVICE TECHNOLOG 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER ALICE CLAGETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7/05 MARRIOTTSVILLE ROLD MARRIOTTSVILLE MD 21104 DOROTHY ANN JONES / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LAKEVIEW Men. PK. 2/10/2006 Sykesville, mo 22. Name and Address of Facility JN ZUMBOWN FIT & MON. Co. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, excomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ELDEISBURG-MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final Syndrome (ARDS) **Physician** Two weeks Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the ettending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No Ö 9☐ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? secondary to ad Enocuncina 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: ours after death.

Interest Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 29c. License number 017873 29d. Date signed (Month, Day, Year) Truis , M.D. February 8, 2006 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
Manabull A. Levine 6569 Warth Charles Street 4 31. Date filed (Month, Day, Year) State 1 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 7 2006 **Physician** Marion Desmond Krupnick 2:45p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Continuum Care At Sykesville Syksville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 12 12 15 Syksville Carroll 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 🎖 🗆 F 073-10-1431 90 1915 NY Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State r than "natural", or itema 23a or 28a-f show the Medical Examiner must be coulied at Md Carroll Sykesville 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7553 Hummingbird Court 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) legal secretary clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked other. Frederick James Desmond Veronica Winieski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick S. Krupnick (son) 7553 Hummingbird Ct., Sykesville, Md 21784 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Whitehaven Mem. 2-13-06 Rochester, NY 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee

Parage Parage Turneral Service P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2nd Stay, UVE.
Due to (or as a consequence of): **Physician** disease or condition resulting in death) 2nd circhosis Wer ylans /Medical Examiner Vears patocellules Cercanon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi gastruntestrai resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one, examiner's Other: 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Director: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0062975 Weishaan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Stones Ave. #307, Westminster MDZ1157 atny 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 0 2006 Registrar

Physic	an	1 - For Amend Items#2 Registrar 1. Decedent's Name (First, Middle, Lie								2. Date of De Month	Reg. No.		3. Time	
/Medi	cal	Mary Theresa Kinc								FEB	05	200	6 8:4	5 1
Examir	ner	4a. Facility Neme (If not institution, gi				4b. City, T	,	Location of			4c.	County of De	ath N/A	CI
uneral irector		214-76-0437	Sex 1□M 2ŽF	7. Age (In yr. 45	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan . 18	th Year) 1961	9. B Hav	irthplace (State Sountry) 7re deGi	
show	_	Usuel Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation							10d. Inside (
28a-f	Funeral Directo	Maryland N/ 10e. Street and Number	A	Ba.	ltimore	10f. Zip C	odo.				10- Citi		1 ₫Ye	s 2[
3a or	Ö	2910A Northern Pk	TATS#			101. 240 0		214				zen of What C Lted St	1	
ams 7	ner	11. Marital Status	12. Was Dece	edent Ever in		Vas Decede Yes, specif	nt of His	spanic Ori	gin? (Sp	ecify Yes or No		14. Race - Am	nerican Indian,	
item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Modical Examinar must be invitted at	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Giv Year or D	2 ⊒*N o ve		☐ Yes 2[Specify:	i, rueno	ricali, etc.)		Black, Wh	hite Thite	
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other than	e Co	17. Father's Name (First, Middle, Las	N/A			Self E	_		r's Name	(First, Middle		ome Cle	an1ng	
arked o	To B	Delbert Lee Kinca	id							esa Bro		<i>'</i>		
ls mar Burnal	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (I Route Numbe			Zip Code)	
ther tra		Mr.Vincent James	Kincaid			+1 Twi		e Dri	ve .	Port Ri	Lchey	, Fla.	34668	
·		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐	Removal from	State	Place of Dispos cemetery, crem	atory or oth	er place			ate		cation - City o		
rtant:		*4 □ Donation 5 □ Other (Speci	(y)	E	zans Fur					1			-	-
Important: I any injury o once.		21. Signature of Funeral Service Lice	nsee	Jan,	A. Pe	Name and eacefu 325 Yo	Address 1 A rk F	of Facility Ltern Road	y lativ Tim	es Fundonium.	ral& Marv	Cremat	ion Ct1 21093	r.
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sician		Immediate Cause (Final disease or condition	AN	OXIC	BRA	IN	NI	JUR	Y				Onset and	
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ician and burial-transit	Еха	resulting in death) Last	·	or as a conse										
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tor.	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1 🗆 1 0 3	2 2 140	
this cer al direc	2	1 ☐ Yes ♣☐ No	Hospital:	npatient 2	ER/Outpatient	3□ DOA	Other	4 🗆 Nur	sing Hon	ne 5 ☐ Resid	ence 6	□Other (Spe	ecify)	
fter	on:	27. Manner of Death 1 ⚠Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury		Injury a Work?	at	2	8d. Describe h	ow injury	occurred		
or:	icat	2 ☐ Accident investigation 3 ☐ Suicide Could not b	Α	44.1		М		es 2 🗆 N						
0 0	Certification:	4 Homicide determined	Zoe. Place	of injury - At r ig, etc. <i>(Speci</i>	nome, farm, stre	et, factory, o	ffice		2	8f. Location (S City or Tow	treet and n, State)	Number or Ri	ural Route Num	n <i>ber</i> ,
To the Funeral Dir completely filled in	edical	29a. Certifier Cortifying Ph	ysician: To the illust: On the ba and mann	sis of examina	owledge, death ation and/or inve	occurred at a	he time my opir	, date and nion, deat!	place, a	nd due to the o	ause(s) a late and p	and manner as place, and due	s stated. to the cause(s	s)
To the	Me	29b. Signature and title of certifier				29c. L	icense r	number			29d. Date	signed (Mont	h. Day, Year)	
		aver	M	.0.		R	ES	000)		FEB	, 05,	2006	
											- 0	/		
a		30. Name and address of person who TAREG ABOU- KHA	completed cause	of death (Ite	m 23a) (Type, P	rint)	VI				111			-

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certific	cate of	Death		Reg	J. No.	
	Physici	an	1. Decedent's Name (First, Middle, La				-			Date of Death Month	Day Year	3. Time of Death
	/Medi		Winifred Eileen	Kirkner					Fe	bruary	03, 2006	5:30 A.M
	Examir	ner	4a. Facility Name (If not institution, giv			4b.	City, Town, or	Location of	f Death		4c. County of Dea	
			Dulaney Towson N			- () (6)		wson	241100		Baltimor	
	Funeral Director		5. Social Security Number 6. S 214-38-0916 Usual Residence of Decedent	5ex	e (In yrs. last birtl 64 Y	rs. Mor	Inder 1 Year oths Days	If Under 2 Hours	Min. Ju	Date of Birth Month, Day, Y ne 29,	ear)	thplace (State or Foreign ountry)
	/land		10a. State 10b. County		10c. City, Town	or Location)					10d. Inside City Limits
	the Man 28e-1 sh notified	Director	Maryland Baltimo:	re County	Towso		f. Zip Code			10	0	1 □Yes 2 No
	s 23a or		111 West Road				21	204			United	States
920	be filed within 72 hours after death with the Maryland tal Hygene. d other then "natural", or Items 23a or 28e-1 show event, it a M. Alc. Exter'il at must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1/21 If Yes, Give Year or Dates:			ecedent of H specify Cuba es 22 No	ispanic Orig in, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whi	
215-0036	thin 72 h e. en "natu Malical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		(Give kind o	Usual Occupa of work done of OT use retired	durina most	of working	16	b. Kind of Business	/Industry
7	ygien ygien ier th	Son	12	N/A		Sec	retary				State of I	Maryland
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Maryland	12 s h ar 7 ls trau		19a. Informant's Name/Relationship (_			City or Town, State	Zip Code)
	s 1 and of Health item 27 other to	1 8	Mary Kathleen Moo	ore (Sister			ivia Ro		Chase,	Maryla	and 21220 c. Location - City or	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	y)	20b. Place of I cemetery Evans	Funer	al Cha	pel (2/9/0)6 I	Forest Hi	ll, Maryland
Rai	permit Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	F. gai	r, Ar.	Peace 2325	eful A York l	f of Facility Road	atives Tinon	Funera ium, Ma	al&Cremat aryland	ion Ctr.,P.A 21093
			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the	mode of dyin	g, such as c	cardiac or res	spiratory arrest		Approximate Interval Between
ŀ	Physician		Immediate Cause (Final disease or condition	· Caro	inamo	itor	s n	Um	noit	· -		Onset and Death
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O. BOX	death d for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		ic pregnancy r (specify)				23d. Date of del Month	ivery Day Year
as, r	The law requires that the te has been signed by tho age 2 should be detached.	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in t	the underlyi	ng cause give	n in Part I.				the cause of death?
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DIVISION	or Atten after deal Director: in by the	Certification;	3 Suicide 6 Could not be determined		ry - At home, farn . (Specify)				28f. l	ocation (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	edical C	29a. Certifier (Check only one) 1 Certifying Ph	ysicien: To the best oniner: On the basis of and manner sta	examination and/	death occur or investiga	rred at the tim tion, in my op	e, date and inion, death	place, and o	lue to the caus the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	omple	Me	29b. Signature and title of certifier	A			29c. License	number		29d.	Date signed (Monti	n, Day, Year)
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	3		30. Name and address of person who self-control of the American American American American American American Science (1997).	BITMI, E.	21 N E	ype, Print)	WST	Sni	te 308	BA	LTIMORE	mD 21201
H	Sta Registr	0.00	31. Date filed (Month, Day, Year) FEB 1 0 2	32. B égistra	r's Signature	Special	وع					

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Baltimore, Maryland 21215-0036 Demil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 ehow any Injury or other treumatic event, the Medical Examinar must be notified at once.	To Be Completed by Funeral Director	Elem
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			1 - For State Ragistrar	State	of Marylar		artment o			Mental H	ygier Reg. M	E-sea	16	038	34
	4 10	14	Decedent's Name (First, Middle	e, Last)						2. Date of	Death			3. Time o	f Death
	Physici			Carl J	ohn Knud	lsen				Febru	arv .	bay 5, 20	Year 06	7:33	A M
	/Medio		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, To	own, or Lo	ocation of De			c. County		1.00	
1	LAGIM	, di.	Bedford Court	Nursing l	Home		Si	1ver	Sprin	ng		Montg	omer	V	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year I	f Under 24 H	rs. 8. Date of I	3irth			place (State ontry)	or Foreign
l.	Director	or .	089-16-7693	1 ∑ M 2□F	83	Yrs.	Months [Days	Hours M	in. (Month, April	22,	1922		York	
-7	2		Usual Residence of Decedent												
	ryiar	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside C	-
	9 Ma	cto	Maryland Montg	omery		Rockv	ille							1 L Yes	2 🕅 No
	or 20	Director	10e. Street and Number				10f. Zip C	ode			10g. (Citizen of V	Vhat Cou	ntry?	
	23e	B	4204 Heathfie	ld Road				0853				ited	Stat	es	
920	be filed within 72 hours after death with the Maryland ital Hygiene. In the maturel, or Iteme 23a or 28e-f ehow event, the Madical Extratrer man be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 X Yes	2 □ No WW]	T	Was Deceder If Yes, specify 1 ☐ Yes 22	_	anic Origin? Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		k, White,	can Indian, etc. Vhite	
Ö	2 ho	Completed		t's Education		16a. Dece	dent's Usual (Occupation	on		16b.	Kind of Bu	siness/In	dustry	
218	hin 7	pie	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work DO NOT use	reti re d)	ing most or v	vorking		terna			
21	d wit	Š		3		Saf	ety En	gine	er		Bu	sines	s Ma	chines	3
b	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, Ins.M.	Be	17. Father's Name (First, Middle,	Last)				11	B. Mother's N	lame (First, Midd	lle, Maid	en <i>Sumam</i>	re)		
/lai	should be and Mental I s marked o	To	Carl J. Knudse	n, Sr.					Nelli	e Thomp	son				
an	2 sho and ! is ma		19a. Informant's Name/Relations				•			Rural Route Nur					
Σ	Health Health term 27		Helen Louise Kr	udsen/Wi	fe	4204	Heathf	ield	Road	Rockvi	11e,	Mary	land	20853	3
ore	ges 1 end 2 should t of Health and Men if Item 27 is marke or other treumatic		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Demoved from		Place of Dispo cemetery, crea	osition (Name matory or othe	of er place)	Fel	Date oruary 7,	20c.	Location -	City or To	own, State	
Ĕ	Pagenent Int.		4 Donation 5 Other (S		Cro	wnsville	. Veterar	ns Cem	etery	2006		wnsv:	ille,	Mary	1and
Baltimore, Maryland 21215-0036	permit. Pages to Department of Historiant: if Its any Injury or ot once.		21. Signature of Funeral Service	Signature of Funeral Service Ligensee M01305 22. Name and Address of Facility Robert A. Pumphrey Fune: 300 West Montgomery Aver										20850	2805
	*		23a. Part1. Enter the disease, o	Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line.										Approxima Interval Be	te
	Physician		Immediate Cause (Final disease or condition		rosepsis									Onset and Days	Death
	/Medical		resulting in death)	Due to	o (or as a consec	quence of):									·
42°	Examiner		Sequentially list conditions	b											
	₽ ≅	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):									
V	nd Irans	ani	that initiated events	с											
0,	e exe ien a urial-	Ä	resulting in death) Last	Due to	o (or as a consec	quence of):									
8760,	icate be executed physicien and the burial-transit	dical		d	_										
9	artific ing p	0 1	IF FEMALE:												
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗆 Live	outcome of pregna birth 2 Feta gnant at time of c known	aldeath 3	☐Ectopic preg☐ Other (spec				-	23d. Dat Mo	e of deliventh		Year
т, П	res that igned to be det	by P	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cau	se given	in Part I.	23e. Di	d tobacc	o use cont	ribute to t	ne cause of	death?
rds	quire in sig uld b	De D	Diabetes, Atri	al Fibril	llation,	Hyper	tensio	n,		_ 1(Yes	2 🗆 No	3 🗆 Prot	ably 4 🖔	Unknown
of Vital Records,	w requ	Completed	Seizures, Inte	rcerebral	L Hemorr	hage				24a. W	as an	24b. \	Were auto	psy findings	available
Re	The lay	Ë	autopsy performed?								7	death?		cause of	
tal	iclen: Th certificate rector, pag		25. Was case referred to medica						6 Place of F	1 ☐ Yes Death (Check on)		No	Yes	2 NO	
5	Physiclen: r this certifica ral director, I	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other		Home 5□Re		6 □Oth	er (Snecil	(v)	-
o	a Phy eral c		27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o		: Injury a Work?		28d. Describ				,	-
Division	ath. r: Aft	atlo	1 Natural 5 Pendii 2 Accident investi	gation (MC	mui, Day 1 ai)	Injury	м		s 2 No						
<u>×</u>	Atte	Hick	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Pla	ce of Injury - At h	ome, farm, st	reet, factory, o	office		28f. Location	(Street		er or Rura	A Route Nur	nber,
Ö	el or s afte ol Dir	Certification;	4 I Homeldo	Oui	lding, etc. (Speci	<i>'Y)</i>				City or	OWII, JA	2(0)			
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurred at vestigation, in	the time, n my opin	date and plation, death or	ace, and due to the	ne cause e, date a	(s) and ma and place,	nner as s and due to	tated. the cause(s)
	To the within To the Comp	Ĭ.	29b. Signature and title of certifie	or	1		29c. l	License n	iumber		29d. [Date signe	d (Month,	Day, Year)	
			> xmue	render	Alle	en.M.	D D	0057	630		Feb	ruary	76,	2006	
	MXI		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)								
	1		Anuradha Arun,	M.D. 10)301 Geo	rgia A	venue,	#209	9, Sil	ver Spr	ing,	Mary	land	20902	
S	Sta		31. Date filed (Month, Day, Year		Registrar's Signa		P								
1000 1600	Registi	ar	FEB 1	2006	Deliver 1	OF GE	arti)								

		For State Registrar		State of	of Maryla		artment rtificate			Mental H	giene	006	03835
or it		Decedent's Nam	ne (First, Middle,	Last)						2. Date of D	eath	V	3. Time of Death
Physiciai /Medica	_	James	Mayo	Kohl	Sr.					Febru	ary 7	2006	2205
Examine		4a. Facility Name (4b. City, T	own, or Lo	cation of Dea			ounty of Death	
		Upper Ch 5. Social Security 1		e Medical				l Air	Under 24 Hr			rford	
Funeral Director		212-30-7		6. Sex 1 X M 2 □ F	7. Age (in y)	rs. last birthday 2 Yrs.			Hours Min	. (Month, D			place (State or Foreign ntry)
A ·		Usual Residence o			1					Dec. 4	, 1933	Mā	ryland
Irylan show		10a. State	10b. County	_	10c.	City, Town or L						1	Od. Inside City Limits
the Marylar 28a-f show	50	Maryland		ord		Abingd				·			1 Tes 2 No
with th	蔶	10e. Street and Nu 3701 A		y Lane			10f. Zip (n of What Cour	ntry?
Jeath w	Funeral Director	11. Marital Status	· I CIII	12. Was Dec	edent Ever in	U.S. 13			anic Origin? (Specify Yes or N	USA	Race - Americ	an Indian
ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or itema 23a or 28a-f show event, the M. dical Exemples in with be mutified at	by Fun		ried 2 Marrie	Armed Fo	orces? 2 💢 No ive		If Yes, specifi 1 ☐ Yes 2	y Cuban, I	Mexican, Pue Specity:	rto Rican, etc.)		Black, White,	etc.
21215-0036 ad within 72 hours alt giene. or then "natural; or it the Midical Exertal.	ed	3 🗆 🕶	15. Decedent's		Jates:	16a Dece	dent's Usual	Occupation	in .			Whi of Business/Inc	
und 21215-0 be filed within 72 h tial Hygiene. d other then "natur event, the W. dical	Completed	(Spec	cify onfy highest	grade completed)		(Give	kind of work DO NOT use	done duri	ng most of wo	orking	TOD, KING	or pasinessymi	dustry
212 d with giene r the	Š	3	onoary (0-12)	College (1-40(5+)	Gra	ohic A	rtist	:		Conta	iner Ma	nufacturer
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M.	e A	17. Father's Name						18	. Mother's Na	me (First, Middle			
aryla should to and Ment market	0	Frank	u/k		ohl				Mary	u/l			
		19a. Informant's N Doris Ko				19b. Mail 3701	_			ural Route Numi			
e, M 1 and 2 Health Health other tra	-	20a. Method of Dis			20b	. Place of Disp	A osition (Name	Pen	шу ца	Date ADII		Maryra tion - City or To	nd 21009
0 80=5		1X Burial 2	☐ Cremation :	Removal from	State	cemetery, cre	matory or oth	er place)	2 1			-	
	Ī	21. Signature of Fu	5 ☐ Other (Spenieral Service Li		5	pesutia				1-2006		yman, M	aryland
Balt Permit Depart Import Import	-		1			Mo	Comas	Fune	ral Ho	me, P.A	•	. 1	7 01000
*	1	23a. Part1. Enter t shock, or hea	he disease, or	molications that of	caused the de	eath. Do not en	ter the mode	cesou of dying, s	ry Roa such as cardia	c or respiratory	gaon, I	Marylan	d 21009 Approximate
Priysician		Immediate Cause disease or condition	(Final	ny one cause on e	1	1-	■ 1000/43			0 1-1			Interval Between Onset and Death
/Medical		resulting in death)		aDue to	(or as a cons	equence of):	10	e c	eu i	zial	, .		6 how
Examiner		Sequentially list co	nditions,	b				د	163	face	400	~	
executed in and instransit		Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	orlying	Due to	עו מש מ טעוושי	aquence of).							
8760, sate be executed physicien and the burial-transit	Yell	that initiated events resulting in death)	5	c	(or as a cons	equence of):					_		
	. ע			O									
Records, P.O. Box 6: The law requires that the death certific the has been signed by the attending p sage 2 should be detached for use as	M/1	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, out			75				230	I. Date of delive	ry
O. B ne death the attr	200	in the past 12 1 Tes 2	□No		ointh 2 ☐ Fe nant at time of		⊒Ectopic prec ☐ Other (spec					Month	Day Year
P.O. that the ed by the detache		9 🗆 Unknown											
S, res th	2	Part II. Other signif	ficant condition	s contributing to de	eath but not r	esulting in the u	nderlying cau	se given ii	n Part I.		-		e cause of death?
require been signatured should be	ם ב	1504	PULE	Care	non	Nova	they			10	Yes 2 1	No 3 Prob	ably 4 Unknown
Vital Records, sician: The law requires to certificate has been signer rector, page 2 should be of the completed by	1	dealer	tes n	ellitu	ا عجم	Pe II		7		24a. Was	psy	24b. Were autop	osy findings available appletion of cause of
	ر (ر	· · · · · · · · · · · · · · · · · · ·				1 ☐ Yes	2 No	death? 1 ☐ Yes	2 🗌 No
	ן ב	25. Was case refer examiner? 1 ☐ Yes 2 ☑	_	Hospital:	Inpatient 2	Π = D/O-1		04		ath (Check only			
Physical Christon		27. Manner of Deat	n	28a. Date	of Injury	ER/Outpaties 28b. Time o		Injury at Work?	4 Nursing I	lome 5 Res)
Vision of Attending F r death. Sector: After by the funeraling.		Natural 2 Accident	5 Pending investiga		th, Day Year)	Injury	М		2 🗆 No				
Division C Ital or Attending P Is after death. The Director: Attent Ital of the tuner Certification:		3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could no determin	200. Place	of Injury - At	home, farm, st	eet, factory,	office	•	28f. Location (Street and N wn, State)	lumber or Rural	Route Number,
Dital or urs after ral Dir	ַ ב												
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	200	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the aminer: On the band man	best of my ki asis of examii ner stated.	nowledge, deat nation and/or in	n occurred at vestigation, in	the time, of my opinion	date and place on, death occi	e, and due to the urred at the time,	cause(s) and date and pla	d manner as sta ace, and due to	ated. the cause(s)
To the within 2 To the comple		29b. Signature and	title of certifier		· · · · · · · · · · · · · · · · · · ·		29c. I	icense nu	mber		29d. Date s.	igned (Month, L	Day, Year)
		1	1	3- h			D	0 (2)	535	68	Tebra	uarz P	7006
6	<	30. Name and addr	essor person w	no completed caus	e of death (Ite	em 23a) (Type,	Print)		3,			70	,000
		-yeffy	3 A	1 houpes	ono MT	D 50	o Up	2er (hesas	seaked	V. Be	LASC. I	, 2006 MD 21014
State Registrar		31. Date filed <i>(Mon</i>	1 0 200	32. R	egistrar's Sign	nature	-		1			, ,	-

			1 - For State Registrar	State of Ma		d / Depa	artment of I	Health ar	nd Mental Hy	_	bie.	13836
			Registrar 1. Decedent's Name (First, Middle, Lasi	:t)	-	Cei	rtificate of	Deam	2. Date of D	Reg. No.		3. Time of Death
П	Physic		Charles C. Kuo	•/					-Month,	Day	Year	8:13 PM
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of I		4c. County	of Death	0.131
r	_xami	*	Levindale Hospita	ıl			Baltir			N/A		
	Funeral		5. Social Security Number 6. Se	D	e (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. 12/13/	rth ay, Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		Usual Residence of Decedent	510 201	82	Yrs.			12/13/	1923	China	a´´
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	a-fsh	ctor	MD Howard		Co	lumbia	a					1 ☐ Yes 2🍆 No
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event; the Medical Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Coun	try?
	s 23a	ral	10629 Hickory Cre		F		21044			USA		
_	ter de Item	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 \(\text{Yes} \) 2\(\text{C} \) 1		i. 13. \	Was Decedent of F f Yes, specify Cub	fispanic Origin an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Rac Blac	e - America ck, White, e	an Indian, etc.
3	al', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:		Specify	. Asia	ın
9500-61212	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)		16a. Deced	dent's Usual Occup	oation	f working	16b. Kind of Be		
7	within ne. han *	mple	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done OO NOT use retire					
	filled v Hygie ther t		17. Father's Name (First, Middle, Last)	5+] .	Mater:	ial Scier		INEET Name (First, Middle	Electr		5
yland	ed at a	To Be	Hui-Ting Kuo					7-2-2	ing Wang	o, Maideil Sulliali	16/	
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	g Address (Street	1	or Rural Route Numb	per, City or Town,	State, Zip	Code)
, Mar	1 and 2 Health a lem 27 is		Sze-Ping Kuo/Daug	hter		7109	Rivers V	7iew Co	urt Colu	mbia, MD	210	144
9			20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ F	Removal from State	20b. Pla	ice of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or Tov	wn, State
baitimore,	mit. Pages partment of ortant: If it injury or o		`4 ☐ Donation 5 ☐ Other (Specify))	Metr		natory			Catonsvi		
ga	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	_ MDI	142				Harry H. 1 a Pk. E-			ly FH Inc. MD 21043
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused	the death.	Do not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multi.	- 0050	un Pi	retem.	fails	w			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as),	10000				
		3.	Sequentially list conditions,	b. Sens	S ()	nea offi						
	uted J ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events									
ĵ.	exectan and and rial-tra		resulting in death) Last	Due to (or as	a conseque	ence of):						
3/00,	ate be nysicia he bu	Ical		d								
20	ertifica ling pl	Physiclan/Med	IF FEMALE:			_						
XO PO	attend for us	lan/	in the past 12 months?	23c. If yes, outcome	2 Fetal d	leath 3	Ectopic pregnancy	/		23d. Dat Mor	e of deliver	y Day Year
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of dea	ith 5	Other (specify) _					,
7 <u>.</u>	that ned by deta	by Ph	Part II. Other significant conditions con	ntributing to death bu	ut not result	ing in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?
necoras,	quires an sign uld be		Covonary anter	y disea	se,	atri	of fibr	ellation	a 10	Yes 2 No	3 🗌 Proba	bly 4 □Unknown
ည က	aw re	plet	Hypertención (Lystinic	demi	~	,		24a. Was		Vere autop	sy findings available
Ē	The I	Completed	00	0					autor perfo	mined?	leath?	pletion of cause of 2□ No
VII	cian: ertific ector,	Be (25. Was case referred to medical examiner?						Death Check on			
5	Physic this c	7°	1 ☐ Yes 2 No P	Hospital: 1 Inpatie			t 3□ DOA Oth	4 🗀 Nursii	ng Home 5 ☐ Resi			
	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day		8b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2∐No	280. Describe	how injury occurre	эа	
VISION	Atten r deat sctor: by the	ertification;	3 Suicide 6 Could not be	286. Place of Inju	ury - At hom	ie, farm, stre				Street and Number	er or Rural	Route Number,
5	s afte	Cert	4 Homicide	building, etc	c. (Specity)				City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier Check only one) Certifying Physical Exami	sician: To the best of iner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred at the tir estigation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) and mai date and place, a	nner as sta ind due to t	ted. the cause(s)
	To the	Me	29b. Signature and title of certifier	+			29c. Licens			29d. Date signed	(Month, D	ay, Year)
			DA. Mil	~ , M	9		D06	6017	0	02/	09/2	006
-	0		30. Name and address of person who co				Print)				-1-	
,			31. Date filed (Month, Day, Year)	32. Registra	/Inda							
	Sta Registr		1	OOR 32. Hedistra	ar o oiynattii	M. A.	books					

			1 - For State Registrar	State of M	arylar		artment tificate			and Me		giene			383	7
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La Tanet Kick Kick Aa. Facility Name (If not institution, given				4b. City, T	own, or	Location o		2. Date of De Month FCDVU(1)	ry G		ear OG G Death	3. Time of 0	
	Funeral Director		5. Social Security Number 6. 3 218–28–1192	Lyview Med Sak 7. Ag 10 M 274 F	1Cd e (In yrs. 73	Certer last birthday) Yrs.	Balf If Under 1 Months	1mc Year Days	If Under: Hours	Min	8. Date of Bii (Month, De)4/02/	rth ay, Yea <i>r)</i> 1932). Birthp Coun	lace (State or try) and	Foreign
	72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show dical Examilies must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A			ty, Town or Lo timore									0d. Inside City	
	death with t ma 23a or 2 rmust be n	Funeral Dire	10e. Street and Number 304 Elrino Street 11. Marital Status	12. Was Decedent	Ever in U	J.S. 13. y	10f. Zip C 2122 Vas Decede	4 nt of His	spanic Orig	gin? (Spec	ify Yes or No	Uni	izen of Wh ted S 14. Race -	tate	eS an Indian,	
-0036	hours after tural', or ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	1	Yes, specif	No.	Specify:	ī, Puerto R	lican, etc.)	16h K	Black, Specify:	White,	te	
2121	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-f show other traumatic event. It a Musical Examilies must be notified at	Completed	(Specify only highest gr Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Lasi	ade completed) College (1-4or 5	i+)	(Give life, L Kinder	kind of work OO NOT use	done de retired)	uring most eache	r		Priv	ate :		,	
Maryland	2 should be fi and Mental H Is marked of sumatic ever	To Be	John Sas 19a. Informant's Name/Relationship (19b. Mailin	g Address (Fran	ces ((First, Middle Cecelia Route Numb	a Sza	abels		Code)	
a)	0 0		John M. Kielek Sr 20a. Method of Disposition 1 Burial 2 Cremation 3 Companion 5 Other (Special Special Removal from State	20b. f	304 E Place of Dispos cometery, cren k Lawn	sition (Name natory or oth	of er place)	Da		20c. Lo	cation - Ci	ty or To		a	
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral, Service Lice	4. Webe	r Ci	5P 22	Name and	Address We Ches	of Facility eber ster	y Funer Stree	al Hon	nes I			and 21	
196	Physician /Medical Examiner		23a. Part f. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ne. 		er the mode	of dying	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Betwo Onset and De	
60, 60	be executed ician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coll S Dies to (or as Due to (or as		uance of):										
Box 6	death certific e attending pl ed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ➡ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	ıldeath 3□	Ectopic preg						23d. Date o Month		ry Day Ye	ar
	faw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of METASTATIC COLO-	vectal Car	ut not res	sulting in the un	derlying cau	se giver	n in Part I.						e cause of dea	
tal Rec	The ate h page	e Completed	25. Was case referred to medical						50 BL		1 ☐ Yes	psy ormed? 2 No	prio dea	r to con th?	isy findings av apletion of cau	vailable use of
Division of Vital Records,	d is	To B	P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other											(Specify)	
Divis	i ji te	Certification:	3 Suicide 6 Could not be determined	building, etc	: (Specif	(y) 				28	City or To	wn, State)		Route Numbe	91,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exam 29b. Signature and title of certifier	nysician: To the best of miner: On the basis of and manner sta	examina	tion and/or inv	estigation, in	my opi	e, date and inion, deat number	d place, ar h occurred	d at the time,	date and	and mann- place, and e signed (A	due to	the cause(s)	
	/		30. Name and address of person who) Mack	eath (Iten	n 23a) (Type F		2E	5-0	00	ļ	Febr	uary	9,	2006	
:116			ALEICIA MA 31. Date filed (Month, Day, Year)	32. P gistra	E	ASTERN		UE	BAC	TIM	ORE,	MD	212	24	4	
- 18	. No.		31. Date filed (Month, Day, Year)				AVEN	UE	BAC	-TIM	ORE,	MD	212	-24	<u>′</u>	

			1 - For State Registrar	State of Ma	aryland / I	Departm <i>Certific</i>			d Mental Hy	giene	nn	in the	038	38
			Decedent's Name (First, Middle, Last	it)			410 07 1	J 04.11	2. Date of De			1	3. Time of [Death
	Physici		ALVERTA		/ Δ	MBD	てん		Febra	Day		ear So 6	(9:1	
7	/Medic Examir		4a. Facility Name (If not institution, give	street and number)				Location of D	eath		County of		1 (. ,	-)
			The Johns Ho	okins He	Spital		salts	more	city		N	I/A		
	Funeral		5. Social Security Number 6. S	9x 7. Age	e (In yrs. last bi	rthday) If Ur Mont	ider 1 Year	If Under 24 I	Hrs. 8. Date of Bir	th	9	. Birthpla	ace (State or	Foreign
	Director		213-04-1285	LIM 201F	98	Yrs.			June 7	″190.	7		" MD	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10	d. Inside City	y Limits
	Mary -1 sh	ţō	Maryland N/	7			Ra	Itimore	2				1 🛛 Yes	2 No
	r 288	Director	10e. Street and Number			10f.	Zip Code	10111101		10g. Citiz	en of Wha	at Countr	ry?	
	23a c		2515 Boston Str	eet Apt. 6	505			21224			USA	1		
	dea r	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was De	cedent of H	ispanic Origin?	(Specify Yes or No Jerto Rican, etc.)	p 1	4. Race -	America White, et		
36	or th	by F.	1 Never Married 2 Married	1 ☐ Yes 2 ☐XN If Yes, Give	10		s 2 ⊠ No	Specify:	2010 1 110411 1 0101/		Specify:		nite	
Ö	hour tural'	d be	3 Widowed 4 Divorced	Year or Dates:	1 460									
S	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		. Decedent's l (Give kind of life. DO NO	work done o	durina most of	working	16b. Kin	d of Busin	.ess/indu	ıstry	
212	y with	E O	Elementary/Secondary (0-12)	College (1-4or 5	+)	Но	memak	er		Н	ouseh	old		
פַ	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show svent, the Madical Examinar must be notified at svent, the Madical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Mother's i	Name (First, Middle,	Maiden S	Sumame)			
<u>la</u>	should by	70 5	Joseph Cramb	litt				Mine	rva P	riber	2			
Maryland 21215-0036	01 03 -2 63		19a. Informant's Name/Relationship (7						Rural Route Number					
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altimore,	Pages intent of Hunt: if ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		cemete	f Disposition (ry, crematory	or other plac	e) Feb). Data 08		ation - Cit			
Ħ	it. Pa rimer riant njury		4 Donation 5 Other (Specify		Oakla	wn Ceme		15 70					arylan	
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			23a. Part 1. Enter the disease, or come shock, or heart failure. List only	lications that caused one cause on each lin	the death. Do	not enter the r	node of dying	g, such as card	diac or respiratory ar	rrest,		A	Approximate Interval Between	veen
1	Physician		Immediate Cause (Final disease or condition	. Acit	re d	Trove						9	Onset and De	eath C
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):								O V
H		_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as :	a consequence	ot).								
V	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (0. 00	2 001100 4001100	01).								
,	execunation and in all-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						+		
8760,	icate be executed physician and s the burial-transit	dical		d										
	ng ph	Med	IF FEMALE:											
Вох	death certifi e attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		3 ☐Ectopi	pregnancy			23	d. Date of			
o.	0 0 0	sici	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of death	5 Other	(specify)				Month	D)ay Y∈	ear
<u>.</u>	The law requires that the de tte has been signed by the a page 2 should be detached t	by Physician/Me	Part II. Other significant conditions co	ntributing to death by	it not resulting in	the underlyin	a cause and	on in Part I	23e Did to	phacco us	o contribu	to to the	cause of dea	ath?
Records,	signé d be		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, and andony	g causo give	итит дт.	1 🗆 Y	^	~		bly 4 □Un	
Ö	w require been sig	Completed							24a. Was	-				
Ř	he la e has ige 2	dmo							autop	SV	prior deat	r to comp	sy findings av pletion of cau	use of
		ပိ	25. Was case referred to medical					00 Diagonal	1 ☐ Yes	2 2 No	10	Yes 2	□ No	
	Physician: this certific ral director,	0 8	examiner?	Hospital: 12 Inpatier	nt 2 ER/Ou	toatient 3	DOA Othe		Death <i>Check only o</i>		Other (Canada)		
<u> </u>	g Phya	L I	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. 1	ime of	28c. Injury Work		28d. Describe h			Spacity)		
Division of	ath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation	(WOMM, Day	, our,	njury M		res 2 □No						
Ž	irector by the property of the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, street, fac	tory, office		28f. Location (S City or Tow		Number o	r Rural F	Route Number	er,
_	To the Hospital or Attending Phywithin 24 hours attended. To the Funeral Director: After the completely filled in by the funeral		20a Cartifica		,									
	Hos 24 ho Fun etely i	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of the basis of and manner state	examination an	o, death occurr d/or investigat	ed at the tim ion, in my op	e, date and pla inion, death or	ace, and due to the occurred at the time, o	cause(s) a date and p	nd manne lace, and	r as stat	ed. he cause(s)	
	Nithin Fo the	2	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (N	fonth, Da	ay, Year)	
			1 Pend of m	ni mod	200	otes	Roc	-001	, 1	eb o	N.	1LL	200	G
	2	1	30. Name and address of person who c	ompleted cause of de	ath (Item 23a)	Type, Print)	1-03	-020	3Actimor	=IM+	1 PYL	ANI	212	3+
)		30. Name and address of person who co PARIAN TO AN 31. Date filed (Month, Day, Year)	1 The J.	ohns	Japkin	-s Hos	pitel	600 N	ORTY	i vu	OLF	STR	GET
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Lacido	D	*	•					

			For State Registrar	State of Maryla	-	artment of H			ene 1.006	03839
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las	IMN) Li		4b. City, Town, or	Location of Death	2. Date of Death Month Februar	Day Year y 7 2-0 4c. County of De	06 3:00 pm
	Funeral Director		5. Social Security Number 6. S N/A	ex 7. Age (In yrs	cuth s. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) March 4,	Monta (ear) 9.48 1934 C	omecy inthplace (State or Foreign Country) nina
	the Maryland 28e-f show culfied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom 10e. Street and Number	_	Ckville			100	ı. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 ☒ No
' 0	be filed within 72 hours after death with the Maryland and Hygiene. And Hygiene and Hygiene and other than "natural", or terms 23e or 28e-f show event, the Modical Exertical rulest be notified at	Funeral Dir	914 Allan Road 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No		20850 Was Decedent of Hi f Yes, specify Cuba			China 14. Race - An Black, Wi	nerican Indian,
Maryland 21215-0036	thin 72 hours a e. en *natural', o Modical Exer	Completed by	3 AWidowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	If Yes, Give Year or Dates: ducation ide completed) College (1-4or 5+)	16a. Decec (Give	1 ☐ Yes 2 ☒ No tent's Usual Occupa kind of work done of the open	furing most of work)	king	Specify:	
/land 21	be filed Ital Hygi of other	То Ве Соп	17. Father's Name (First, Middle, Last) Ziyi Li	4		nistrator	18. Mother's Nam Biyi Ta			
	ges 1 and 2 should to f Health and Mer it item 27 is marke or othar traumatic		19a. Informant's Name/Relationship (Qian Tang/Son 20a. Method of Disposition 1□Burial 2□Gremation 3□	20b.	914 Place of Dispo	Allan Roa sition (Name of natory or other place	d, Rockv			0850
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: If Item 27 ii any injury or othar tra once.	6 4	4 Donation 5 Other (Specification) 21. Signatur of Funeral Service Lice	y) C1	ontgóme remator Ro 00803 Ro	T-2-0	10	2006 B	ethesda, umphrey ntgomery 2805	Maryland Funeral Home/ Avenue
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	one cause on each line.	equence of):	Failu			it,	Approximate Interval Between Onset and Death 2 veets
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burlat-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
Records, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	1 ☐ Yes	2□No 3□	to the cause of death? Probably 4 Unknown
Vital Rec		Be Completed	25. Was case referred to medical examiner?			Щ	26. Place of Dea	24a. Was an autopsy perform 1 ☐ Yes 2, th (Check only one	prior to death 2No 1 ☐ Yo	autopsy findings available ocompletion of cause of ? es 2 No
of	ding Phy I. After this funeral d	ို	1 Yes 2 Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time o	f 28c. Injun Worl	4 Nursing H	ome 5 Residen 28d. Describe how		Decify)
Division	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not be determined	building, etc. (Spen	ncify)	h occurred at the tin	ne, date and place	City or Town,	State) use(s) and manner	Rural Route Number, as stated.
	To the Ho within 24 t To the Fu completely	Medical	(Check only 2 Medicel Exerone) 29b. Signature and title of certifier	miner: On the basis of examinand manner stated.		29c. Licens		29	d. Date signed (Mo $\frac{2}{7}$	
	Sta		30. Name and address of person who Neelima De 31. Date filed (Month, Day, Year)		tem 23a) (Type,			ve Bet	hesda,	MD 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 03840 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Lyle 07:12 AM В. housey 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SWAL ACTIMORE

Under 1 Year If Under 24 Hrs. 8. Date of Birth
Inthis Days Hours Min. (Month, Day, Year) iffeT (MOTTE OF 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10 M 20 F 96 Director 212-14-0117 07 09 1909 SC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or U.S.A. 21215 Funerai 3800 West Belvedere Ave Apt 1010 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Baltimore, Maryland 21215-003 Specify: Black 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "na eny injury or other traumatic event. Ite Media. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mable Young Henry Mosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April A. Newman-God-Daughter 1542 Kirkwood Road, Baltimore Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 2/2/06 Laurel, Md 21. S@nature on Funeral Service Licensee 22 Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P 11. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia ASP 170T LOA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Division of Vital Records, P. After this death. Director: hours after

MOWNAS:

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within 24 hours a To the Funeral L

State

Be

Certification: To

Medicai

Mame and address of person who completed cause of death (Item 23a) (Type, Print) P. MARK GOLDSTEN 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

25. Was case referred to medical examiner?

29b. Signature and title of entities

1 ☐ Yes 2 ☐ No

27. Manner of Death

2 Accident 3 🗀 Suicide

4 Homicide

29a. Certifier



M.O.

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28a. Date of Injury (Month, Day Year)



28c. Injury at Work?

1 Certifying Physician: To the hast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On-the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO061529

BALTIMORE

1 ☐ Yes 2 ☐ No

autopsy performed? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JANUARY 28, 2006

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death | Check only one

1 ☐ Yes 2 ☐ No

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 03841 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 08, 2006 1:04 p M Joyce K. Loper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lutherville Baltimore Brightwood Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. | 30, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Pennsylvania 86 Yrs. Director 170-18-7453 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits in than "natural", or items 23s or 28s-f show the Medical Exercines must be notified at Baltimore Md. Lutherville Director 1 ☐ Yes 2 TXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 800 Roundtop Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Persis Klahr Klepfer Ensworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mr. Terry Loper/ Son 5384 Viewpoint Ct. Sykesville, Md. 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Depertment of He
important: If iten
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Warren, Pa. Oakland Cemetery 2-13-06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licersee 23a. Part1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MonteCell Immediate Cause (Final LYMPHOMA **Physician** mathe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5-quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physicien and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autop-performe 2) certificate 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death Check only one 2 No Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŏ After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 5 🗌 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours efter To the Funerel Dira ŏ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the h 29b. Signature and title of certifier N. Charles Breet 6601 taullour MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2006

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			1 - For State Registrar	State of I	Maryland / D	epartment Certificate			ind Men		ene) 0 6	03842
	Physici /Medic Examin	al	Decedent's Name (First, Middle, L. Marie T. 4a. Facility Name (If not institution, gi	Mar	tin en	4b. City,	Town, or	Location o	Fel	Date of Death Month	Day Year 8 200 4c. County of Dea	3. Time of Death 9:35PM
	Zami	-	Franklin Wood	s Nursi	ng Home	Re	osed	dale			Baltimo	re
	Funeral Director		5. Social Security Number 6.		Age (In yrs. last birth			If Under 2 Hours	Min. JU	ate of Birth Month, Day, Y ine13,	^(ear) 1919 Ma	rthplace (State or Foreign ountry)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl Fishe	to	MD Balti	more	Es	sex						1 ☐ Yes 2 X No
	th the or 28e e noti	lrec	10e. Street and Number			10f. Zip	Code			100	. Citizen of What C	ountry?
	ath wi	ral	422 Margaret				1221				USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Importent: If Item 27 is marked other than "netural", or iteme 23s or 28s-1 show any injury or other treumatic event. The Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? [7] No	13. Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Specify ` , Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	ite, etc.
2-0	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. [ecedent's Usua Give kind of wor	l Occupa	tion urina most	of working	16	6b. Kind of Business	Industry
Maryland 21215-0036	ed within ygjena. ier than " t, the Ma	Completed	Elementary/Secondary (0-12) 8th	College (1-4		Give kind of wor ife. DO NOT us ectric:	ial	Asse	embly		Glen L.	MArtin
and	ould ba fil Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Las Francis Beeby	t)					r's Name <i>(Fir</i> s nerine		iden Sumame)	
2	2 should and Men is marke	²	19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address	(Street a				City or Town, State,	Zip Code)
Ĭ,	ss 1 and 2 of Health a Item 27 is other tree		John Ruth /	nephew	90)12 Hi	nton	Ave	e. Bal	timor	e MD 21	219
altimore,	Pages 1 and of He nent of He nert If Item		20a. Method of Disposition ↑ Burial 2 ☐ Cremation 3 [☐Removal from Sta	. cemetery	Disposition (Nam crematory or ot	her place		Date		c. Location - City or	
Ħ	t. Pag rtment rtent:		' 4 ☐ Donation 5 ☐ Other (Special	ify)	Gardei	ns of I		i	2/11/0	6	Rossvil	le MD
Ba	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	insee	06.	22. Name and			Conne			meofEssex
			23a. Part1. Enter the disease, or con	polications that cause	sed the death. Do no	Tenter the mode	Ma of dying	ce A	Ve B	Baltim piratory arres		21221 Approximate
	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Tone cause on each	mic / w	maha	1	. /	Pouk	emia		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of): 1	711			C Prijes		
		<u>a</u>	Sequentially list conditions,	b. Due to for	as a consequence of							
	utad d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ö,	cate be executad obysician and the burial-transit		resulting in death) Last		as a consequence of):						
8760	physic physic the bu	dlcal		d								
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		2 Fetal death t at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe					23d. Date of de Month	livery Day Year
Vital Records, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions Amemica Der	contributing to death	h but not resulting in t	he underlying ca	use giver	n in Part I. SVE				o the cause of death?
000	ne law requir has been si ge 2 should I	Completed	Pulmonary Di	sease			_		2	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ř		Com	, , ,						1	performe	d? death? ZNo 1 ☐ Yes	
Z	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Che			
	Phye	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I			-	4 Nur			ce 6 □Other (Spe	ecify)
0	ttending Phy death. stor; After this tha funeral c	atlon	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year) Inj	iry M	3c. Injury Work1 1 ⊟ Y	? es 2 ☐ N			injury coccined	
Division of	To the Hospital or Attending Phyelcien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not to determined	28e. Place of	Injury - At home, farn etc. (Specify)	n, street, factory,	office		28f. L	ocation (Stre	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical (29a. Certifier (Check only one)	hysicien: To the be miner: On the basis and manner	st of my knowledge, s of examination and/ stated.	death occurred a or investigation,	at the time in my opi	e, date and inion, deat	d place, and d h occurred at	ue to the caus the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	,		29c.	License	number		29d	. Date signed (Mon	th, Day, Year)
	7		You Elm	nolow	MO		45	766)	Fe	brury	9,2006
	10		30. Name and address of person who Tom Edmondson,	MD 9200	Franklin					Smor	e MD 3	1/237
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 0	2006	strar's Signature	posts.	ř	,			/	
						of						

			State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death		ene g. No. 006	03843
	Physicia		1. Decedant's Name (First, Middle, Last) RUSERT MILEO	2. Date of Death Month	Day Year S 2006	3. Time of Death 12:31 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death ANOR CARE - KOSSUILLE KOSSUILLE		4c. County of Death	more
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year of Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	1918 M	pplace (State or Foreign Lintry)
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County 10c. City-Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	in the M or 28a-f e notifie	Funeral Director	MD BALTIMORE DALTIMORE 106. Street and Number 107. Zip Code	10	g. Citizen of What Cou	
	eath wit	erai D	4307 SELMAR AVE. 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	ecify Yes or No-	USA 14. Race - Amer	ncan Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show apprintly or other traumatic event, it is Marical Examinational profiled at an	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Fes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	Rican, etc.)	Black, White	9, etc.
21215-0036	thin 72 ho e. an "natur Mojical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ing 10	6b. Kind of Business/l	
	filed within Hygiene. Ather than ant, the Me	e Con	6 RUCK DRIVER	e (First, Middle, M	RE16	-H1
Maryland	should be nd Mental marked o	To Be	ANTHONY MILEO ROSE	Noto		
	and 2 sho lealth and m 27 Is mu her traum		19a. Informant's Nam. Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 19vce LloyD - DAUGHTER 4434 EAST COTTONIA	JOOD LA	City of Town, State, 2	170-110
nore,	Pages 1 and of Heiston of Heiston of Heiston of Heiston or othe Iry or othe		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) CENO EPARE	Date RY	Oc. Location - City or T	
Baltimore,	permit. Pag Department Important: any injury c				NERAC C NKullE, 1	MA 21274
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Covd' Dv.a.5cu Due to (or as a consequence of):	rse_		Onset and Death
	Examiner	70	Sequentially list conditions, if any, leading to immediate b. b. cabetes Mellytus Due to (or as a consequence of):			
J	sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	dical E	d			
Box 68	certific iding p	in/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deli	
o.	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year
S, D	es ign	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hrice Fibrillation		acco use contribute to	the cause of death?
Vital Record	e law has b	Completed	Coronary gritery disease.	24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
ital	ician: The l certificate ha ector, page	O		1 ☐ Yes ≥ h (Check only one	No 1 Yes	2 No
ō	ing Phys	ion: To B	TSNatural 5 Pending (Month, Day Year) Injury Work?	ome 5 Resider 28d. Describe how		cify)
Division	or Atten iter deal irector n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
\int	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
/	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Month	
•	0.4		MULLIA MD D5 6979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hadai Chardon 758 45 bale Wood 5	7	reb, a,	2086
	8	4.	Hadai Chardon 75845 Dale Ubbool 5 31. Date filed (Month, Day, Year) 33. Registrar's Signature	100	Celeu	burnie
	Sta Registi		31. Date filed (Month, Day, Year) September 1 0 2006 33. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD_0852, 2/28/06 TT

		1- For State Registrar	State of	Marylar		artment rtificate			d Men		ene J. No.	16	038	4
Dhusi		1. Decedent's Name (First, Middle, L.	ast) Kuldip C	. Mehra						Date of Death	Day	Year	3. Time of	Death
Physi /Mei	ician dical		Kudlip	- C. 1	Mehra				Fe	bruary	5, 20	006	1:58	P^{M}
Exam		4a. Facility Name (If not institution, gi	ve street and numi	ber)		4b. City, T	Town, or	Location of De	ath		4c. Count	y of Death		
		Suburban Hosp					hesd				Mon	tgome	ery	
Funera Directo		146-86-1358	Sex 7 1∭2 M 2□ F	'. Age (In yrs. 81	last birthday) Yrs.	If Under	1 Year Days	If Under 24 H Hours Mi	in. (/	Date of Birth Month, Day, 1 Vember 1.	(ear) 5, 1924	Cou		or Foreign
pu *		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or Lo	cation							10d. Inside C	ib. Limita
•ho	7					Cation								2 X No
the N	Director	Maryland Montgor	nery	Po	otomac	104 7:-	0-4-			100	1. Citizen of	14/1 1 0		
with with	급		D	00		10f. Zip (,					,	
eath	era	9440 Newbridge I	12. Was Deced		18 13 1		2085	spanic Origin?	(Specify		nited		can Indian,	
fter d	Funeral	1 Never Married 2 Married	Armed Ford	es?		f Yes, speci	fy Cubar	n, Mexican, Pu	erto Ricar	n, etc.)	Bla	ick, White,	etc.	
US a urs a	Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			1□Yes 2	No X	Specity:			Specia	^{fy:} Asia	an-Ind	ian
C 21215-UU36 Ilied within 72 hours after death with the Maryland Hygiene. wher then "naturel", or Iteme 23a or 28e-1 ehow ent, Ite Medical Examinat the motified at	Completed by	15. Decedent's E (Specify only highest g.				ient's Usuai				16	ib. Kind of B	Business/In	dustry	
Lithin 1	nple	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. I	DO NOT use	e retired)	uring most of w	vorking					
N dien King	်		4		Pi	lot					Airl	ines		
Tal Hard	Be	17. Father's Name (First, Middle, Las	t)					18. Mother's N	lame (Fire	st, Middle, Ma	iden Sumai	me)		
Via ould Men Men watic	P									Channa				
BAITIMORE, MARYIAND 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23a or 28e-1 show any injury or other traumatic event, the Medical Exactions metal by a conflict	1	19a. Informant's Name/Relationship Raman K. Mehra						y Road,			•			
C, I and teath ther ther		20a. Method of Disposition	3011	20h I	Place of Dispo			y Koau,	Date	_	c. Location			
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: if Item;		1 ☐ Burial 2 🌠 Cremation 3		tate	cemetery, cren	natory or oth	her place		cuary	10,				_
Itin		4 □ Donation 5 □ Other (Spec	•	Mon	tgomery (. Name and			2006	E	ethes	da, M	lary1ar	ıd
		> Conjecto On	isamt	м0130)5 Rol 75	bert A. 57 Wisc	Pump consi	ohrey Fun n Avenue	, Beth	nesda, M	aryland	Chevy 1 2081	Chase, 1 -3501	Inc.
– Physiciai		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	used the dear ch line. PS i S	th. Do not ent	er the mode	of dying	, such as cardi	iac or res	piratory arres	t,		Approximat Interval Bet Onset and I 1 Day	ween
/Medica	_	resulting in death)	Due to (o	r as a consec	quence of):								-	
Examine		Sequentially list conditions.	b	eumoni									1 Day	
/ pg #s	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ras a consec	quence of):									
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cate be executed physicien and the burial-transit	dicalE				,									
	edlo		u											
Geath certifi death certifi e attending I d for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ir					23d. Da	ate of deliv	ery	
death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of c		Ectopic pre Other <i>(spe</i>					Mo	onth	Day '	Year
at the de	hy	9 Unknown												
- × -	þ	Part II. Other significant conditions Dementia-Alzhei			sulting in the ur	nderlying ca	use givei	n in Part I.		23e. Did toba				
w require	Completed	Dementia Miznei	mer 3 ry	pe					- 6	1 ∐ Yes	2 💢 No	3 ∐ Prot	oably 4 □l	Jnknown
VITAI HECOTAS, sicien: The law requires t certificate has been signe rector, page 2 should be o	a dr								_ 2	24a. Was an autopsy		prior to co	psy findings mpletion of c	available ause of
	ပ်								1	performe ☐ Yes 2		death? 1 ☐ Yes	2 No	
VITAL sicien: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:				Othor	26. Place of D	eath (Chi	eck only one				
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ding h. After	Į.	1 X Natural 5 ☐ Pending	(Month,	Day Year)	28b. Time of Injury	M 20	c. Injury Work	at ? es 2 ∐No	280.1	Describe how	injury occur	rreu		
DIVISION OF VITA and or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not l	oe Diese e	f Injury - At h	ome, farm, stre				28f. L	ocation (Stre	et and Numi	ber or Rura	al Route Num	iber.
	ert	4 Homicide Getermined	building	, etc. (Specia	(y)					City or Town,	State)			
Hospital or 24 hours afte Funerel Dir	edical (29a. Certifier 1 Certifying P	hysician: To the b miner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred a restigation, i	t the time in my opi	e, date and pla nion, death oc	ce, and d curred at	ue to the cau the time, date	se(s) and mage and place,	anner as s and due to	tated. the cause(s	.}
To the within 2 To the complet	₹ S	29b. Signature and title of certifier				29c.	License	number		29d	. Date signe	ed (Month,	Day, Year)	
, , , , ,	1	17	lurar	W.D		1	D365	52		Fe	bruar	y 5.	2006	
		30. Name and address of person who			n 23a) (Type,	Print)								1 1
	1	Pankaj Talwar, M			Edmonst	on Dr	ive,	#401,	Rock	xville,	Mary	land	20852	
S	tate	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ature	astes								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Janh Ronald Eugene Miller, Sr. 28 20°0'6 6:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3538 McShane Way Dundalk 8. Date of Birth (Month, Day Year) 2-2-42 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 🖫 M 2 🗆 F 212-40-1568 63 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rithan "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits MD Dundalk XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3538 McShane Way 21222 U.S.A. Funerai filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) Electronic Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fil tment of Health and Mental H tent: If Item 27 is marked oth jury or other traumatic even Woodrow W. Miller Alma J. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Miller (Wife) 3538 McShane Way Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XDBurial 2 ☐ Cremation 3 ☐ Removal from State Department or important: if any injury or once. Crownsville 1-31-06 Arundel Co. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Funeral Service Licensee 2007 Eastern Ave. Balto. MD 21231 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ERMUNAT LUNG CANCER MONTH /Medical Due to (or as a consequence of): Examiner S - uential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed of Vital 1 Yes 2 No To the Hospital or Attending Physician: After this certification, Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medicai Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 Natural Injury i diter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the eauce(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) January 31, 2006 1445931 rere 30. Name and address of person who cou pleted cause of death (Item 23a) (Type, Print) 7220 Park Hoights Ave Bultimore, MD 21208 parah 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryl	•	artment of F			ne 2006	03847
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medio		Catherine Ruth Mil	es.				Month	Day Year	458 AM
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County of Death	2 1
			CITIZENS CAR.	2 9 KEHAT	B. CITR.	HAVE	EDEC	FRACE	HARL	ond
	Funeral		Social Security Number 6. Sex	4 X15	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birthi	place (State or Foreign
	Director		219-28-4270	73	Yrs.			12/23/19:	32 Mary	länd
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl f sho	5	NO Hayland							Yes 2□No
	the t	Director	MD Harford 10e. Street and Number	П	avre de	10f. Zip Code	<u> </u>	100	. Citizen of What Cou	ntry?
	with Se or	Ö		. Aut 70/						
	ns 23	Funeral	505 Congress Avenue	2. Was Decedent Ever i	in U.S. 13.	21078 Was Decedent of H	lispanic Origin? (Sp		USA 14. Race - Americ	can Indian.
(0	r Iter	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🕱 No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White,	
03	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "neturel", or Items 23e or 28e-f show ther the Medical Examination Legitled at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation	ing 16	b. Kind of Business/In	dustry
21	thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	1		during most of work d)	,,,,,		
2	ygien ygien t, the	S	GED		House	keeping N			Hospital	
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other then eumetic event, the Ma	2	Andrew Hughey					ive Chars		
lar	2 sh and is m		19a. Informant's Name/Relationship (Type						ity or Town, State, Zip	
	1 and 1 Health em 27 other tr		Bernard E. Mills, S	Sr Husband	d 505 C b. Place of Dispo	ongress f				
Baltimore,	Pages nent of Hunt: If ite		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Re	emoval from State	cemetery, crei	natory or other plac	ce)		c. Location - City or To	
Ë	t. Pa rtmer rtent:		`4 □ Donation ´5 □ Other (Specify)		The second secon	is & Co.	101/26		st Chester	z, PA
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents if item 27 is marked other then "neturel", or Items 23e or 28e-f show way injury or other treumetic event, the Medical Examinet must be rediffed at once.		21. Signature of Funeral Service License	5	Mi	tchell-Si	nith Fune	ral Home,	P.A.	
	20200	-	23a. Part1. Enter the disease, or complic	ontions that sourced the s					Grace, MD	21078 Approximate
			shock, or heart failure. List only on	e cause on each line.	Jeath. Do not en	er the mode of dyr	ig, such as caphac	Influence of the state of the s	'	Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		LUNG	OH B	with 1	1017		
	Examiner		f	Due to (or as a con	sequence of):			5.		
		e.	Sequentially list conditions, b	Due to for as a con	sequence off:				-	
J	nsit	ij	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,					
<u>,</u>	be executed sician and burial-transit	Examin	resulting in death) Last	Due to (or as a con	sequence of):					
8760,	cate be executed physician and the burial-transit	dicail	L _d							
9		0								
Box	death certifi e attending I id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of pre		Ectopic pregnancy			23d. Date of delive	ery
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ F		Other (specify)			Month	Day Year
P.0	at the de by the a tached	hys	9 ☐ Unknowk	9□ Unknown		-				
	The law requires that the tee has been signed by thoage 2 should be detache	by F	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	0 1
ord	w require been si should b							1 🗆 Yes	2 □ No 3 □ Prob	pably 4 Mnknown
Records,	e law ri has be	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
H		COL						performe	d? death? No 1 ☐ Yes	2 No
Vital	Physicien: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of V	Physic this ce al dire	2	1 ☐ Yes 2 No	ospital: 1 Inpatient :	2 ER/Outpatier	it 3□ DOA Oth	er: Nursing Ho	me 5 🗆 Residend	e 6 Other (Specif	y)
n		:uo	27. Manner of Dealin 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea.	r) 28b. Time o	28c. Injur Wor	y at k?	28d. Describe how	injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division		Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (Stree City or Town, S	it and Number or Rura State)	Al Route Number,
	pitel purs a erel [200 Codilion NT Continue Phys	inion. To the book of more	Janes Janes		11		()	
	To the Hospitel or within 24 hours after To the Funerel Direct completely filled in the second completely filled in the second control of the second contr	edical	29a. Certifier Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exan and manner stated.	nination and/or in	vestigation, in my o	ne, date and place, pinion, death occur	ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	o the	Me	29b. Signature and title of Pertifier	11		29c. Licens	e number	29d	Date signed (Month,	Day, Near)
	->-0		1 Thomas 1.	Sweeth M	7		14240	0	1/20	1.00
	1		30. Name and address of person who con	mpleted cause of death ((Item 23a) (Type.	Print)	1000	6 1	11/1/1/	1
	3		Thomas.	GIONDO M	3 314	5. IM	on M	4 40	0,1411	210/12
	Sta		31. Date filed (Month, Day, Year)	32. Jegistrar's S	ignature	ه مدن		1	/ //	
	Registr	ar	FEB 1 0 201	JO REMENSI	15 13	3421			,	

			1 - For State Registrar	State of Maryl		artment of H		F	10g. No. U U 6	03848
90	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yea	
	/Medic	al	John P. Molin 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deal	Februar	y 5, 2006 4c. County of De	9:05 P M
	Examin	er	Stella Maris	are and number y		Timon			,	ltimore
The State of the S	Funeral Director		5. Social Security Number 6. Sex 212-01-4174		yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min		Year 916 M	lirthplace (State or Foreign Country) aryland
	and and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d, Inside City Limits
	Maryl 1 sho	tor	Maryland N/A			Baltim	ore			1 N Yes 2 No
	with the	I Direc	10e. Street and Number 410 S. Eden Stre	zet		10f. Zip Code	21231		10g. Citizen of What U.S.A.	Country?
036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23s or 28e-1 show svent, it a Medical Eram at must be mutiled at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2[X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify: (X	
21215-0036	ithin 72 ho ne. han "natur e Medical I	mpleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wa	orking	16b. Kind of Busines	
ב ב	filed withi Hygiene. Other than		12th Grade 17. Father's Name (First, Middle, Last)		Lith	ographer	18. Mother's Na	me (First, Middle,	Lithograpi	iers
au	0 - 5	To Be	Louis Molino				Anna	Tana		
Maryland	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic s ance.	-	19a. Informant's Name/Relationship (Type Mrs. Carolann Cune	•		-			r, City or Town, State	
re,	of Hea		20a. Method of Disposition	20		esition (Name of matory or other place		Date	20c. Location - City	
Ē	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Gardens	of Faith	Cem: 2/9	7/2006	Baltimore,	, Maryland
Baltimore,	permit. Depart Import any inj		21. Signature of Fineral Sovice Conse		9	705 Berai	r Rd., I	Baitimore	Funeral Ho , MD 2123	
3.	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each	5 4 m 6		g, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
8/60, P	certificate be executed individual by sician and itse as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con						
O. Box 6	death certific e attending p d for use as	Physiclan/Medle	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
ords, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	•				1	bacco use contribute	to the cause of death?
Z Z	The ate h	Completed	Mr/201650	lorde	en d	o Wieler	dio	24a. Was a autop perfor	sy prior to med? death	
VITal	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner?	ospital:	2 □ ER/Outpatier	Other		ath Check only or		
on or	fter	tion: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		28c. Injun Work			ence 6 Other (Spow injury occurred	овспу)
DIVISION	al or Attendi safter death I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occi	e, and due to the curred at the time, c	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	withii To ti	W	29b. Signature and the of certain.	will me	9	29c. License	number 1550		29d. Date signed (Mo	nth. Day, Year)
	0,		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print)				
100			EDDIE NAKHUDA, M.I. 31. Date filed (Month, Day, Year)	D. 2300 DUI		LLEY ROAD	TIMONI	TUM, MD 2	1093	
	Sta Registr		FFR 1 0 20	ING Accuse	A A	asoli)				

FEBRUARY 5, 2006

		State of Maryland /	Certificate of		tal Hygiene Reg. No.	06 03849
Physician /Medical	1. Decedent's Name (First, Middle, Last)	Moone	4		Dete of Deeth Month Dey	Year 3. Time of Death
Examiner	4e Fecility Neme (If not institution, give s Manor Care Dulaney	treet and number)		4b. City, Town, or Location Towson	_	y of Deeth Ctimore
Funeral Director	220 20 7337	M 2 F 7. Age (In yrs. last	birthday) If Under 1 Year Yrs. Months Days	Hours Min. 8. C	Date of Birth Month, Day, Year) Lt. 11, 1930	9. Birthplece (State or Foreign Country) Maryland
permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Baltimor 10e. Street end Number 4116 Lochcarrow	Road 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Yeer or Dates: ation Completed) College (1-4or 5+) Classe Triend 4 20b. Place ceme Entombment Gard	21236 Hispanic Origin? (Specify: an, Mexican, Puerto Ricar Specify: pation during most of working dt) 18. Mother's Name (Fire Adele tand Number or Rurel Roi 10 nd Drive, Da	Yes or No- n, etc.) 10g. Citizen of U.S. Yes or No- 14. Ra Bit Speci 16b. Kind of E wood we Number, City or Town Baltimore, 106. Baltimo	10d. Inside City Limits 1 Yes 2 No Whet Country? A. ce - American Indian, ack, White, etc. by: White Business/Industry Own Home me) n, Stete, Zip Code) AD 21236 - City or Town, State tre, MaryLand	
ath certificate be executed attending physicien end manipulation and manipulation and properties of the puriel fransit are clan/Medical Examiner	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest	Right Sided 1 Due to (or as Due to (or as		CerebroV	ascular ac	Approximate Interval Between Onset and Death
aw requires that the d is been signed by the 2 should be detached pleted by Physi	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying cause gi	3	1 ☐ Yes 2 ☐ No 24a. Was an eutopsy performed?	antribute to the cause of death? 3 Probably 4 Anknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
To the Hospital or Attending Physician: The it within 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, pege	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Certifying Physical	28a. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At home, building, etc. (Specify) clan: To the best of my knowled.	Time of Injury M 28c. Inju Wo 1 Time of Injury M 28c. Inju Wo 1 Time of Injury M 1 Time o	ry at rk? 28d. I rk? Yes 2 □ No 28f. L	5 Residence 6 Ot Describe how injury occu ocation (Street and Num city or Town, Stete)	ber or Rural Route Number,
To the Ho within 24 I To the Fu completal	29b. Signature and title of certifier 30. Name end eddress of person who cor	er: On the basis of examination a and manner stated	and/or investigation, in my o	opinion, death occurred at	the time, date and place	and due to the cause(s)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

FEB 1 0 2008

32. Registrar's Signeture

		•	For State Registrar	State of Maryland		rtment of H tificate of L			iene g. No.	03850
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Linwood Burn	s Morton				2. Date of Deat Month	Day Year 27 200	3. Time of Death T'. 30PM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Ellico	Location of Death	1	4c. County of Dea	1
y i	Funeral Director	759	5. Social Security Number 6. Sex		t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bit	thplace (State or Foreign ountry)
	aryland ehow	_	Usual Residence of Decedent 10a. State 10b. County HOW 0	10c. City, T						10d. Inside City Limits
	ith the M or 28a-f	Funeral Director	10e. Street and Number	inale	7/1co	10f. Zip Code		1	0g. Citizen of What C	
	death w	neral	4028 Aggy U	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	Spanic Origin? (S	pecify Yes or No-	USA 14. Race - Am	
030	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or fleme 23a or 28a-f ehow event, the Madical Examitter hast be notified at	þ	1 Never Married 25Married 3 Widowed 4 Divorced	1 Myes 2 No If Yes, Give Year or Dates:		Yes 2 XNo	Specify:	o riican, etc.)	Black, Whi	slack.
3215-0U36	in 72 ho n "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 1 completed) College (1-4or 5+)	16a. Deced (Give	ent's Usual Occupa kind of work done o OO NOT use retired	ation during most of wor)	king	16b. Kind of Business	/Industry
N	filed with Hygiene othar tha		12th grade 17. Father's Name (First, Middle, Last)	Ayears	Che	mical I	Engline 18. Molher's Nan	ne (First, Middle, I		Sovernment
yiand	Mental Mental arked c	To Be	James L. Morre				Henrie	Ha W.	nght	
Mary	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship (Ty) Alice J. Monon	Mife	19b. Mailin	g Address (Street a	and Number or Ru		, City or Town, State, H City N	Zip Code) 1D 21042
ore,	- I i i		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R	emoval from State	e of Dispose etery, crem	sition (Name of natory or other place			20c. Location City of	
Baitimore,	permit. Pages Department of Important: if i any injury or once.		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens							. MD 21229
10 0	:		23a. Part 1 Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	Do not ente	or the mode of dying				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen		rest	. •			sudden
4	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	nce of):	Infar	_			
	ecuted and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent		rtery [Disease	/		
8760	icate be executed physicien and s the burial-transit	dical E		l						
O. Box 6	ath certif attending for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
<u> </u>	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significent conditions cor		ng in the ur	1			pacco use contribute	
cord	w requir been si should	ieted	Diabetes Hyp	remension,	пүр	eviplae	mia	1 🗆 Ye	n 24b. Were a	robably 4 Unknown utopsy findings available
= Re	The lascate has	Completed						autops perform 1 Yes	y prior to ned? death?	completion of cause of
Vita	s certification of the sector.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatien	t 3□ DOA Othe	00	ome 5 Reside	e) ence 6 □Other (Sp	ecify)
Division of Vital Records,	To the Hospitei or Attending Physicien: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	ation; T	27. Manner of Death 1 Maturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun Work	/ at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	ei or Atte s after dea il Directo ed in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	dural Route Number,
	To the Hospitel or A within 24 hours after To the Funaral Directorpletely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	11		29c. License	e number	2	9d. Date signed (Mor	th, Day, Year)
ŗ	, DY		30. Name and address of person who pe	mpleted cause of death (Item 2:	1 (Type,	Print) 101	0000	0 10/1	ebrnary	2,2006
	/.0		31. Date filed (Month, Day, Year)	Olomon, 32. Registrar's Signatur	H.L	0. 182	00 1114	MUTTE	e ka,	Ballo 21208
*	Sta Regist			06 Brown &	· An	action .				

		1 - For State Registrar		ryland / Dep		lealth and I	Mental Hygie	ne ne	03851
Physic	ian	1. Decedent's Name (First, Middle, Las			_		2. Date of Death Month	Day Year	3. Time of Death
/Medi		James	P.	MC	Namara		February	1 2006	2:02 P ^M
Exami	ner	4a. Fecility Name (If not institution, give		77.		r Location of Death	ר	4c. County of Death	
		2460 Brentwood At 5. Social Security Number 6. S		LLOOL (In yrs. last birthda)	Baltimo	ore If Under 24 Hrs.	8. Date of Birth	N/A	place (State or Foreign
Funeral Director			MM 2□F	63 Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) Cou	place (State or Foreign ntry) N.Y.
show		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
Marfal	io	Md. N	A	Bal	timore				1 XYes 2 No
or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
ath w	G	2460 Brentwood				218		USA	
er de Items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
ours after death with the Maryla raf', or Items 23a or 28a-f shov Exeminar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓☐ Divorced	1 □Yes 2 N If Yes, Give Year or Dates:	0	1 ☐ Yes 🎢 No	Specify:		Specify: W	hite
within 72 hours after death with the Maryland ene. than "natural, or items 23a or 28a-f show he Modicel Examinational be notified at	bed	15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occup	pation	16	b. Kind of Business/Ir	
hin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5-	(Giv	e kind of work done DO NOT use retired	during most of word)	king		•
il Hygiene. other then	mo.	8th grade			sabled			NA	
be filed ital Hygie id other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	
2 should be and Mental is marked o	2	Walter		cNamara			rude		
ges 1 and 2 should be filed within 72 hc to flealth and Mental Hygiene. If Item 27 is marked other than "nature or other traumatic event, the Medical		19a. Informant's Name/Relationship (7						ity or Town, State, Zi	
s 1 and 2 f Health item 27 other tra		Joann Lange 20a. Method of Disposition	Friend	20b. Place of Disp		vood Aven	ue, Baltir		21218
Pages nent of H int: If its iry or of		1 SyBurial 2 ☐ Cremation 3 ☐		cemetery, cri	ematory or other plac			c. Location - City or T	
그 든 문 은 .		4 ☐Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lices	. 2		cmel Cem. 22. Name and Addre			Dundalk, M	
Depa Impo any i		21. Signaturant Funeral Service Licen	19		March F.	-	Baltir	nore, Md. E. North A	21202
Medical Examiner Asicien and burial-transit	Ical Examiner	Sequentially list conditions. Tay least to module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):					
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy	,		23d. Date of deliv Month	ery Day Year
uires that signed t d be det	þ	Part II. Other significant conditions of		t not resulting in the	underlying cause giv	en in Part I.		co use contribute to t	
w requir been si should	ete	0					24a. Was an		
: The lay cete hes	Completed						autopsy performe 1 Yes 2	prior to co	opsy findings available impletion of cause of 2 No
sician: Th certificete irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		ort all post Oth	95	th (Check only one)		
ding Phy:	tlon: To	1XXes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y 28b. Time	of 28c. Injur Wor	y at	ome 5 Residence 28d. Describe how	e 6 ∰ X ther (Speci injury occurred	(v) Scene
ospital or Attending hours after death. unarsi Director: Aftei ly filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, s . (Specify)			28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number.
T 4 11 0	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best on the basis of and manner state	examination and/or i	ith occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
To the I	Me	29b. Signature and title of certifier		\	29c. Licens	e number	29d	Date signed (Month,	Day, Year)
- > - 0		Hotel A.a	nice t	2000	OCME		TD.	praioss o	2006
,)		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		-	F 6	ebruary 2,	2000
	ate	AtRICIAAT 31. Date filed (Month, Day, Year)	Onica - P	r's Signature) 111 Pe	nn Stree	t Balrimor	e, Maryla	nd 21201
Regist		FEB 1 0 200	632	At Age	منطقه				

DHMH 17 Rev 1/2001

ORIGINAL

Eugene March
06-00857
NJM

Physici
/Medic
Examir

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.		3. Time of Death
ian cal	Eugene Edward March, Jr.		February	3 2006	1838
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	h	4c. County of Death	1
	Good Samaritan	Baltimore y) If Under 1 Year If Under 24 Hrs		N/A	
	5. Social Security Number 213-70-6928 Cusual Residence of Decedent 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthda) 38 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Ye Dec. 15, 1	ar) 9. Birth Coul 1967 Mari	place (State or Fore intry) Land
	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Lim
ctor	Maryland Harford Jo	рра			1 ☐ Yes 2 🔀 I
Completed by Funeral Director	10e. Street and Number	10f. Zip Code		Citizen of What Cou	untry?
era	344 Enfield Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (5		U.S.A.	ican Indian
Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer —————————————————————————————————	to Rican, etc.)	Black, White	, etc.
Ď	3 ☐ Widowed 4 ☑ Divorced tf Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: Wh	ite
etec	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wo	rking 16b	. Kind of Business/li	ndustry
d E	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) Carpenter	Se	lf-Employ	od Cannon
0	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		000 000 000
To B	Eugene Edward March, Sr.	Debora	h Taylor		
		iling Address (Street and Number or R			ip Code)
	The same of the sa	Enfield Road, Jo		1085 Location - City or T	our State
١.	I Dunai 2 Micromation 3 Dromoval nom State	cosition (Name of ematory or other place)			
	4 Donation 5 Other (Specify) Bayview 21. Signature of Funeral Service Licensee	Crematory $\frac{1}{2}$ 2/6 22. Name and Address of Facility $\frac{5}{6}$	/2006 Ba	noral Ham	marykana
١.	Jane H/c-C 9	705 Belair Rd., B	altimore.	MD 21236	es
Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
	IF FEMALE:				
Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year
Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	. Le
Completed			24a. Was an autopsy performed	? death?	opsy findings available on pletion of cause 2 No
Be	25. Was case referred to medical examiner? Hospital:	26. Place of De	ath (Chick only one)		
5.	XIX 165 2 NO 1 Inpatient 2XXEH/Outpati	ent 3 DOA 4 Nursing	Home 5 ☐ Residence		ify)
ation	27. Manner of Death 1 Natural 5 Pending (Month, Day Yeer) 2 Accident vinvestigation Fnd 2/3/2006 Fnd 6:0	Work?	unk	.,,	
Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify) Found in dwelling		28f. Location (Street City or Town, St Baltimore, M		ral Route Number, Se Avenue
edical	29a. Certifier (Check only one) 1☐ Certifying Physicien: To the best of my knowledge, dei 2☑ Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause	e(s) and manner as	stated. to the cause(s)
Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Dey, Year)
	I hude M. Ligan	OCME	Febi	cuary, 4,	2006
	30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)			

JC 06-00836 Ricky Medley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department

0.00	to of Dogth	0.7
artment of Health and Menta rtificate of Death	Reg. No.	0303
artment of Health and Menta	al Hygiene	0005

			1 - State Certificate						ertificate of Death Res						leg. No. UUD UJBJJ		
	Physici	ın	1. Decedent's Name (First, Midd		Don			Ma	dley	,	2. Date of Month		Day	Year	3. Time of Death		
	/Medic	al	Ricky 4a. Facility Name (If not institution			none	4h Cih		r Location		Febru	ary		2006 by of Death	22:25 P M		
	Examin	er	Good Samaritia					timo		OI Death			4C. Count	y or Death			
			5. Social Security Number	6. Sex		e (In yrs. last birthda		r 1 Year		r 24 Hrs.	8. Date of	Birth		9. Birth	place (State or Foreign		
h	Funeral Director		104-86-4874	X □M 2□F		19 Yrs	Months	Days	Hours	Min.	8. Date of (Month, O7	Day Y	^(ear) 86	Jam	aica		
	<u>o</u>		Usual Residence of Decedent											-			
	how		10a. State 10b. Count	•		10c. City, Town or								1	10d. Inside City Limits		
	Ma Ma	Director	MD N	A		Baltim	ore								1 X Yes 2 □ No		
	ith th	Jr.	10e. Street and Number				10f. Zi	p Code				100	g. Citizen of What Country?				
	23a	la l	3804 Bartwoo	d Road				2	1215	<u> </u>			Ja	maic	a		
	r dee	Funeral	11. Marital Status	12. Was Dec	orces?		3. Was Dece If Yes, spe	edent of H	ispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or Rican, etc.)	s or No- 14. Race - American India ltc.) Black, White, etc.					
036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to f Health and Mental Hygiene. If item 27 ie marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified.	þ	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Gi	ve	No.	1 ☐ Yes	2 ∕ O No	Specify	<i>/</i> :			Specify: Black				
S.	72 h netu	ete		nt's Education est grade completed)		(G	cedent's Usi	ork done	during mo	st of work	ing	16	b. Kind of Business/Industry				
21215-0036	d within giene er then	Completed	Elementary/Secondary (0-12) 12th grade	College (na	1-4or 5	5+)	. DO NOTE Crew			•			McDo	nald	¹s		
Maryland	be file ntal Hy of oth	Be (17. Father's Name (First, Middle	, Last)							e (First, Mide	dle, Ma	iden Suma	me)			
<u>ā</u>	should b ind Ment marked umatic e	70	Phillip Medl	ey					Dah]	lia :	Simms						
a	2 sho and I ie ma		19a. Informant's Name/Relation								al Route Nur						
	1 and 2 Health tem 27		Dahlia Lawre	nce-Moth	er	380	4 Bai	ctwo	od I		, Bal	-			21215		
5	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Permayal from	State	20b. Place of Discemetery, of	sposition (Na rematory or	ime of other plac	(8)	(Date	20	c. Location	· City or To	own, State		
Ĕ	Pages nent of I ant: If its ury or o		4 Donation 5 Other (State	K i ng Me	moria	al P	ark	2/1	1/06	Ra	andal	lstc	wn, Md		
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signature Funeral Service	Licensee	10	ut ?	larch	rd Addre	ss of Faci Wes	it Ave,	Balt	imo	ore,	Md	21215		
	Pnysician /Medical Examiner		23. Par Enter the disease, sh.ck, or heart failure. Lis Im late Cause (Final disease or condition re-uning in death)	-a. 676	us	the death. Do not		de of dyir	g, such a	s cardiac	or respirator				Approximate Interval Between Onset and Death		
	100	ē	Sequentially list conditions if any, leading to immediate	b. Due to	(or as	a consequence of):											
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events														
o`	exec en en rial-tr		resulting in death) Last	Due to	(or as	a consequence of):											
68760,	ite be iysici	cai		d													
	ertificate be executed ling physicien end se as the burial-transII	Medicai	IE EEMALE.														
O. Box	the deeth c y the ettend iched for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	in the past 12 months? 1 Yes 2 No 1 No Pregnant at time ol death 5 Other (specify)									23d. Date of delivery Month Day Yea				
۵.	that ned by deta	y Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								cco use cor	ntribute to t	he cause of death?				
rds	quires in signi uld be	ed by		1 ☐ Yes 2 2 No							2 2 No	3 ☐ Prol	oably 4 []Unknown				
tal Records,	The law requires that ste hes been signed b page 2 should be deta	Completed									pe	itopsy informe	d?	prior to co death?	opsy lindings available impletion of cause of		
ā	an: The la tificete he tor, page 3	ပိ	25. Was case referred to medic	al					06 01-	on of Dect	12 Ye		J No	1 Yes	2 ☐ No		
_	a 25 S	w	LU. 1143 LASE ICIUITU IU ITIOCIC	CA.I					25 Plac	TERCITOR H	TI TI JACK ON	DE ON A					

To the Hospital or Attending Physicia within 24 hours after death.

To the Funeral Director: After this cert completely filled in by the funeral direct Division of Vi

examiner? 1 Yes 2 □ No Medical Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

(Check only one) 29b. Signature and title of

28e. Place of Injury - At home, Iarm, street, Iactory, office building, etc. (Specify)

Car in aus Statio

28c. Injury at Work?

O.C.M.E.

1 ☐ Yes 2 ☑No

Deceased Allo 28f. Location (Street and Number or Rural Route Number, City or Town, State) E. Cold Spring and Baltinum, MD ZIZIZ York Rd.

February 03, 2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. 12. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Segistrar's Signature

FEB 1 0 2006

5 Pending

investigation

6 Could not be determined



Hospital: 1 ☐ Inpatient 2 IXER/Outpatient 3 ☐ DOA

2-2-06 21:45 PM

28b. Time of Injury

28a. Date of Injury (Month, Day Year)

State

Registrar

			For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene Neg. No. () (16	03854	
		ja,	1. Decedent's Name (First, Middle								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic		Daniel	Patrick	Mo	cLain					Februar	су б, 2	006	1:00 p ^M	
	Examin		4a. Facility Name (If not institution,						Location of				4c. County of Death		
			Harford Memor					IVE 1 Year	de Gi		O. Data of Bird		arfor		
	Funeral		5. Social Security Number 219-44-6001	6. Sex 7. Ag	10 (In yrs. 12 60	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day Jan 15	1946	Mary	place (State or Foreign ntry) 'Iand	
	Director	1	Usual Residence of Decedent									, , , , , , ,	J		
	yland yland		10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Limits	
	e Mar a-f sl	ctor	MD Har	ford		Bel A	ir							1 □ Yes 2 X No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip					10g. Citizen of		ntry?	
	ath w	rai	19 Corns Driv				21 01 5 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				U.S		can Indian,		
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces?		5. 13. F	Was Dece	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	Rican, etc.)	Bla	ck, White,		
36	irs aft	by F	3 Widowed 4 Divorced	ed 1 1 Yes 2 1 If Yes, Give Year or Dates:	Nam		1 Tes	2√2 No	Specify:			Speci	∌∵ Whi	.te	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, I're Medical Examiner must be rediffed at	ted	15, Decedent	's Education		16a. Dece	dent's Usu	al Occupa	ation	t of worki	7.7	16b. Kind of E	Business/Ir	ndustry	
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2	filed withi Hygiene. other then ent, Ite M	Completed				Lin	eman				1 mm		Utili	Ly	
	m = 0 5	Be	17. Father's Name (First, Middle, I							ers Name Sara	(First, Middle,		mpbel	7	
<u>\</u>	2 should be f n and Mental H is marked of reumatic eve	2	Patrick 19a. Informant's Name/Relationsh	McLair	1	19h Maili	na Address	(Street s			il Route Numbe				
Maryland	d 2 st th and 7 is n treun		Christa McLain				heo l	-					, 0,0,0,	, 0000,	
<u>က်</u>	1 and Heali tem 2		20a. Method of Disposition	-uaugiicei	20b. PI	ace of Dispo	osition (Na	me of			ate	20c. Location	- City or T	own, State	
0 10	ages ent of it: If it		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)			emetery, cre 1top = 5				2/13/	0 6	Tows	on, M	1D	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic engone.		21. Signature of Funeral Service									on Fune	ral H	lome, Inc.	
ñ	Depa Depa Impo eny ii		Melle			5 8	1050	York	Rd.	, Tou	uson, Mi	2120	4		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										Interval Between		
			Immediate Cause (Final disease or condition a. Acute respiratory distress syndrome 3 days												
			resulting in death)	Due to (or as	a consequ	ience of):	/				/			-1-	
	Examinei	L	Sequentially list conditions,	b. Due to (or as	2 0000000	iance of							-		
1	od sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
T	xecul and al-trai	Examiner	that initiated events resulting in death) Last	tiad avents C											
8760,	death certificate ba executed e attending physician and ed for use as the burial-transit	dicai													
Ó	tificat ng phy as th	ledi													
Вох	eath certific attending p I for use as 1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic p	regnancy					ate of deliv	very Day Year	
	e dea he att	sici	in the past 12 months? 1 □ Yes 2 □ No	2 No 9 Unknown							Month Say Four				
<u>Р</u>	law requires that the death as been sign a d by the atter 2 should be detached for u	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob						obacco use cor	pacco use contribute to the cause of death?					
Š,	w requires that been signad b should be det	by											res 2□No		
Records,	requ been should	etec		24a. Was an							an 24b	24b. Were autopsy findings available			
Rec	9 4 9	ompieted									autop perfo	rmed?	prior to death?	ompletion of cause of	
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical						26 Place	a of Deatl	1 Yes	2. 10			
	Physician: r this certific ral director,	To B	examiner?	Hospital:	ent 2	ER/Outpatie	nt 3 🗆 D	OA Oth	0.00						
o	tending Physician: leath. tor: After this certific the funeral director,		COLUMN TO A COLUMN						now injury occu	njury occurred and Number or Rural Route Number,					
io	Attending Indeath. ector: After by the funer	atio													
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	1 (4		30. Name and address of person	who completed cause of	death (Item	1 23а) (Туре	, Print)	in e				-2007/6	t acc		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ny **Physician** 274 M 2006 Arbutus Johnson Matthews /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Hospital Glen Burnie 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 84 | Yrs. | Months | Days | Hours | Min. | Jan 10 9. Birtholace (State or Foreign 5. Social Security Number 220-05-5040 **Funeral** 1922 1□M 2□XF Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City. Town or Location J. Hygiene. other than "natural", or Items 23a or 28a-f show yent, the Madical Exeminar must be notified at aMaryland 1 ☐ Yes 2 No Severn Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21144 USA 508 Oueenstown Rd. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lighty or other traumatic event 2008. Matilda Hines Asa Oueen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 692 Stafford Hill Br. Glen Burnie, Md. 21061 Deanna Smoot(Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of A reformed) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2-7-06 Park Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wm Name Red Aggress of Each Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee B. Spere Mc0883 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown/ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificete hes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centifier 29c. License number 29d. Date, signed (Month, Dey, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 BOB: 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#27, perPHY C852, 2/10/06 TT / Department of Health and Mental Hygiene 1 - For State Registrar 03856 Certificate of Death Rag. No: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 7°, 2006° **Physician** 4PM MILLARD JACK J /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | December 15,1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2□ F New York 74 123-22-0824 Yrs. Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10h County r than "natural", or Itams 23s or 28s-f ahow the Medical Examiner must be notified at 1√XYes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 2706 Montibello Terrace USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Menta! Hygiene.
7 Is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Residential & Commercial Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christina Pavon Solis Jack Millard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 le m any injury or other traum once. Jack A Millard Jr Son 19905 Quiet Valley Court Parkton Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 2/11/06 GreenMount Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septicenia 2 weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securitary list on after e, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA ို ŏ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred cetactol bed / F 27. Manner of Death 28b. Time of 28c. Injury at Work? Set aid hed Feel to Floo re. about not sait 281. Location (Street and Number of Rural Route Number, City or Town, State) Certification; Division 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 06 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide MANDECARE RUXTON NURSI Thane 7001 N. Charles Street Bactom) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number D25643 Name and address of person who completed cause of death (Item 23a) (Type, Print) i 0 (600) N. Charles Street, adoll R Faulkner MD, 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

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Funeral			6. Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 24 H		ate of Birth fonth, Day,	Vear	9. Birth	nplace (State or Foreign untry)
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	8		30. Name and address of person who con Shakunmala 9 31. Date filed (Month, Day, Year) FFR 1 0 200	no 30 90	650 Janhay	20 Kaa	of col	ense	14 N N N N N N N N N N N N N N N N N N N		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Negistrar's Signature	Speake						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nő. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 12:33 A^M Thinh-Anh Nguyen-Khoa February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | February 24, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Vietnam 586-46-1531 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **ehow** if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinant result to nutified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 20902 3703 Woodridge Avenue United States Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administrator Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Toan Nguyen-Khoa Khuyen Le ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3703 Woodridge Avenue, Wheaton, Maryland 20902 An Hoang / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot ong injury or ot 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State February Montgomery Crematorium, Inc. 11, 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund al Service Licenses Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCAMIAC Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): ON ON MY ANTER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of):
EN(USCLENATIC HEART ALSEASTE Examiner Hospitel or Attending Physicien: The law requires that the deeth certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Tes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2**∑** № After this certification funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eu 30. Name and address of person who completed cause of death (Item 23a) (Ty -, "rint) Hector Collison, M.D. 8401 Colesville Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Coule FEB 1 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

ORIGINAL

February 4,2006

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			1 - For State Registrar	State of M	/larylan		artmen tificate			and M	lental Hyg	iene	. 000	03861
	Dhusiai		1. Decedent's Name (First, Middle, L	ast)							2. Date of Deal Month	th Da	y Yeer	3. Time of Death
	Physici /Medio				ıley_						Feb.	9,	2006	9:40 A M
	Examin	er	4a. Facility Name (If not institution, g						Location o			40	. County of Death	
			Glen Burnie Heal 5. Social Security Number 6.			tation last birthday)	If Under		Burr If Under 2		8. Date of Birth		Anne Arı	unde L
ь	Funeral Director		577-44-0664	1□M 2\ F		5 Yrs.	Months	Days	Hours	Min.	(Month, Day, June 19	Year)	Cou	nington, DC
	ס		Usuel Residence of Decedent											
	anylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits
	Ba-13	cto	Maryland Anne A	runde1		Glen								1 □ Yes 2 No
	with the	by Funeral Director	10e. Street and Number				10f. Zip		0.44		1	-	tizen of What Co	
	18 23	era	102 Crain Highwa	y N Apt		S 13 1	Was Dogge		061	nin? (Sne	octy Yes or No-	Ur	ited Sta	
10	iter d	F	1 Never Married 2 Married	Armed Force	s?	.3.	f Yes, spec	rfy Cubai	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
036	al', o	þ	3 Widowed 4 Divorced	1 □ Yes 2 If Yes, Give Year or Date	∑ s:		1 ☐ Yes :	No No	Specify:				Specify: W	nite
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madical Examinar must be notified at	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	ition uring most	t of worki	ing	16b. K	(ind of Business/I	ndustry
121	nen hen	ig I	Elementary/Secondary (0-12)	College (1-4d	or 5+)							D		_
2	Hygie Ther t nt, in	ပိ	12 17. Father's Name (First, Middle, Las	et)		Cu	stome	r se			(First, Middle, I		ug Store	2
ano	d be sontal	To Be	Dewey George Mon								ances Ho			
Maryland	shoul nd Me nmarl	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address					_	or Town, State, Z	ip Code)
Ž	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene the fact is the 23a or 28a-1 show Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at		Catherine A. Sta	ake/daught	er	1726	Jacob	s Me	adow	Driv	ve, Seve	rn,	MD 2114	44
ore,	es 1 a of He of He litem		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	□ Domoval from Sta		Place of Dispo emetery, crei	natory or o	ne of ther place	e) T	rebru		20c. L	ocation - City or	Town, State
Ë	Pag ment ant: I		*4 □Donation 5 □Other (Spec		Wes	t Arun	C		tory	14,	2006		enton, M	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lic	ensee		D0	nalds	d Addres	s of Facility	y al Ho	ome & Cr	ema	atory, P	.A.
	40344		23a. Part1. Enter the disease, or co	alianiana that and	O d the deat								MD 211	13 Approximate
			shock, or heart failure. List on	y one cause on each	ine.	n. Do not em	91 (119 11100	e or dynn	y, such as	cardiac	or respiratory arr	031,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	- W	epsis									
	Examiner		1			Melli	tue							
		Jer	Sequentially list conditions, frank, leading to simply cause. Enter Underlying Cause (Disease or injury		as a nonsec		Lus							
1	nd nd transit	Examiner	that initiated events	С.										
0,	death certificate be executed e attending physicien and d for use as the burial-transit	Ex	resulting in death) Last	Due to (or	as a conseq	juence of):								
8760,	physic physic s the b	dicai		d										
9 X	leath certifica attending ph for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcor	ne of preans	ancv						1	23d. Date of deli	ven
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth	2 Feta	Il death 3	Ectopic pr Other (sp					1	Month	Day Year
0	t the c by the achec	hysi	9 Unknown	9□ Unknow	1									
S, D	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to deat	n but not res	ulting in the u	nderlying c	ause give	n in Part I.					the cause of death?
Records,	equire en sig										1. A Y	es 2	!□No 3□Pr	obably 4 Unknown
ecc	2 8 8	Completed									24a. Was a autops	SV	prior to d	topsy findings available completion of cause of
= H	Th ate pag	Con									perform 1 ☐ Yes		death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only or			
ō	phys this al dii	. To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 🗆 Inp		ER/Outpatier 28b. Time o		JA	4 <u>4</u> 4 Nu		me 5 Residence 128d. Describe he		6 ☐Other (Spec	orfy)
Division	Attending F r death. ector: Atter by the funer	ertification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of I (Month,	Day Year)	Injury	М	8c. Injury Work 1 🗆 `	? ∕es 2 🔲 I				,	
Visi	Attendii r death. ector: A by the fu	ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At h	ome, farm, st	reet, factory	, office			28f. Location (S City or Town			ral Route Number,
۵	s afte	Cert	4 [] Hottlede	bullding,	etc. (Specia)y)				ļ	City of Your	n, siai	0/	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	Physician: To the be eminer: On the basi	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, th occur	and due to the cred at the time, d	ause(s late an	s) and manner as id place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner	stated.		290	. License	number		2	29d. Da	ate signed (Montl	n, Day, Year)
	F 3 F 8		And	Danne										
	1		30. Name and address of person wh	o completed cause	of death (Iter	n 23a) (Type.	Print)	וכע	596		1	e D1	cuary 10	, 2000
	9	i	Kandsamy Ambalav	•	•	, , .		l, G1	.en Bı	urni	e, MD 2	2106	51	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature	of .							

			For Stete Registrar	State of Maryland /	Department of Certificate of		Mental Hygier	ZHHB	03862
	Physicia /Medio	an al	1. Decedent's Name (First, Middle, Last) Bruce 4a. Facility Name (If not institution, give s		Peltzer	n, or Location of Death	February	pay Year 5 2006 Ic. County of Death	3. Time of Death 3:35 PM
	Examin Funeral Director		Johns Hopkins Bay V 5. Social Security Number 6. Sex	iew Medical Cente	Balti birthday) If Under 1 Ye	more ar If Under 24 Hrs.		Baltimore 9. Birth	City place (State or Foreign
	D.		Usual Residence of Decedent 10a. State 10b. County		own or Location		1-70-93	S Dett	10d. Inside City Limits
	ih the Mar or 28a-f al	Irector	MD BALTIN	ore.	Dunda K	9	10g. (Citizen of What Cou	1 □ Yes 2 No intry?
	72 hours after death with the Maryland Inatural, or Itama 23a or 28a-f ahow dical Examinat must be notified at	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent	2122Z of Hispanic Origin? (Sp Juban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian,
-0036	hours after turnel', or h	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Mayes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 10 1	cunation	16b.	Specify: W	hite.
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens Hygiens if I tem 27 is marked other than "natural", or itsme 23a or 28a-1 show important: If item 27 is marked other than "natural", or itsme 23a or 28a-1 show arry night or other traumatic event, its Medical Evantual for notified at any night.	Completed	(Specify only highest grade		(Give kind of work do life. DO NOT use re	ne during most of work ired) ILO	ing	N/A.	
Maryland	ould be file Mental Hy larked oth	To Be (17. Father's Name (First, Middle, Last)	Hzer		Doro		(0)	
_	1 and 2 short Health and N Am 27 is ma ther trauma		19a. Informant's Name/Relationship (Ty) Potty Trimble— 20a. Method of Disposition	-friend 1	9b. Mailing Address (Str.	Shrews	bury PA	or Town, State, Zi	
Baltimore,	it. Pages intment of l intant: If Itu njury or o		1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State come	Funeral Cha	Bell 2-	1 00 FC	rest Hi	11 MQ
Ba	Depart Depart Import any inj		23a. Part 1. Enter the diseas, or o mpli shock, or heart failure. List only o	Satrotha	TEACEFUL.	ALTERNATIV	EX FUXERAL or respiratory arrest,	ACREMAT	7 O N CENTER
	Physician /Medical		shock, or heart failure. List only of tmmediate Cause (Final disease or condition resulting in death)	Due to to as a consequence	1				Interval Between Onset and Death
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760, <	te be executed ysicien and e burial-transit	Ical Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consequence			45-1-1-		1 month
	ntificate ng phys as the		IF FEMALE:						
P.O. Box 68	uires that the death certificate be executed signed by the attending physicien and to be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown				23d. Date of deli Month	very Day Year
	The law requires that the ate has been signed by th bage 2 should be detache	ed by PI	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause	given in Part I.	23e. Did tobacc	_	the cause of death?
Division of Vital Records,	ı: The law require icate has been siç r, page 2 should t	Completed					24a. Was an autopsy performed	death?	opsy findings available ompletion of cause of
ΖÏ	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	Outpatient 3 DOA	Other	th Check only one) ome 5 Residence	6 □Other (Spec	u(h)
n of	ng Phy ster thi	on: T	27. Manner of Death 1 Natural 5 Pending		D. Time of 28c. I	njury at Work?	28d. Describe how in		
Divisio	l or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		☐Yes 2☐No	28f. Location (Street City or Town, Sta		ral Route Number,
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	licien: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in m	e time, date and place. ny opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the Comp	ž	29b. Signature and title of certifier,	ill, MD		ense number ES - 001		bruary 5,	, Day, Year) 2006
	1x1		30. Name and address of person who co			Balti	nore, MO	21224	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 0 200	32 Registrar's Signature	Eastern Ave		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [03863 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:351 atrode 2006 Feh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ichrist BAUTIMORE Center TOWSON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 10-352 Yrs Baltimore, MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Yes 2 No Director MD HALTI MORE utherville 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? or items 23e or the Medical Examiner must be 21093 USA 40 MONIUM Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-6036 Specify: Specify: ģ white. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within ratment of Health and Mental Hygiene. ortant: If Itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) tome maker or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Alexandria Wood ward ပ္ arion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ·Son limonium MD 21093 403W. Timonium No Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Dolaney Valley Mem Gardens 2 Injury 4 ☐ Donation 5 ☐ Other (Specify) Monium 22. Name and Address of Facility 21. Signature of Funeral Set YOUR KO. TIMONIUM, MOZIOS any in Peacetul Alkenatives Tunoral o Cremative Center 23a. Part 1. Enter the disease, or cump catum, that caused shock, or heart failure. List only one cuse on each line. Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiralory arrest, Immediate Cause (Final disease or condition resulting in death) tocadeuts muetian erebrovascular Physician 10 days /Medical Examiner erebrovasculor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. ettending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the et id be detached for of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anterioschentic androvascular disecse 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) HOS PLCE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Certification: To 1 🗌 Yes this is 28a. Date of Injury (Month, Day Year) : Alter thi 27. Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospitel or Attending within 24 hours effer death.
To the Funeral Director: Alte completely filled in by the fun 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier all 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) sellers MD. Charles St 6601 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State FEB 1 0 Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 03864 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8 Day Month **Physician** VERNON MAHLON PRICE February 12:58P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 918 Regester Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. November 27, 1918 9. Birthplace (S Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** XX M 2 F 218-01-3436 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 3 ☐ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 918 Regester Avenue 21239 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Wes 2 ☐ No WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married A Married 1 Tes XX No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Photographer Newspaper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be f Mahlon Slaysman Price Rose Gav 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is r any injury or other traur Gary W Price Son 8528 Harris Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 2/13/06 Timonium, Maryland □Donation 5 □Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21 signature of Funeral Service Ligensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or amplications to it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 ScHEmic condiding YEAR /Medical Due to (or as a consequence of): Examiner LOYEM ONM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 00 Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ONGESTIVE P.O. Box 68760, 4 4 Em Completed by Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 TEctopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9☐ Unknown has been signed by to e 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown MITTAR REGORGETATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2☑No 1 ☐ Yes 2 ☐ No certificate ANEMIA THROWSOGTOPENIA 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1-Matural Injury 5 Pending 1 Yes 2 No death. investigation 2 Accident the 1 hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 🗍 Homicide within 24 hours a To the Funeral I filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0028812 06 m om 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent DiPietro MD 7801 York Road Towson Md 21204 Suite 102 2. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 0 2006 State 100 Registrar

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Robert J. Roll Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f,pen/E,8853,379/06 TI State of Maryland / Department of Health and Mental Hygiene 06-0877 AKG 1 - For State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Joseph Roll 2006 February 4, 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3210 Nerak Road Baltimore n/a 6. Sex_ 1 ☐ M 2 ☐ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 31,1954 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Baltimore, MD. Yrs. 213-60-7299 51 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director N/AMaryland Baltimore the 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3210 Nerak Road 21208 United States Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ∑Yes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Roll Ruth Frances Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 1423 Roland Heights Ave. Baltimore, Maryland 21211 Mrs. Deborah Marie Roll (wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Feb. 07, 2006 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alcohol intoxication complicated by positional asphyxia /Medical Due to (or as a consequence of): Examiner side any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be deteched for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 I Unknown page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of teath? has Yes 1 Yes 2 No 2 No ector. 25. Was case referred to medical examiner? 26. Place of Death (Chack only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specifical SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ours after death.

neral Director: After this of filled in by the funeral dire ٩ 1 XYes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Fnd 28c. Injury at Work? 28d. Describe how injury occurred Subject found in Medicai Certification: Division Hospital or Attending 1 Natural 2X Accident 5 Pending investigation 2/4/2006 Fnd 1 Yes 2 No 11:00 A position where cannot breathe 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3210 Nerak Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide dwelling Baltimore, MD To the Hospital within 24 hours a To the Funeral Completely filled in the Funeral Completely filled 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 5, 2006 wo 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) HE ODONE M. Kin 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State FEB 1 0 2006 Registrar

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/Medic		Lois Rogers 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		ANUaryo	4c. County of Death	1007
Examin	°.	Peninsula Regional Medicai	Center	Say	ishury		Wicom	ico
uneral:		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 H/s. Hours Min.	8. Date of Birth (Month, Day, Ye Aug 17, 1	9. Birth Cou 1937 Mary	place (State or Foreign Intry) Land
Mou.		Usual Residence of Decedent	c. City, Town or Lo	ocation				10d. Inside City Limits
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3a or 2	Funeral Director	10e. Street and Number 9289 Stage Road		10f. Zip Code	21875	10g.	Citizen of What Cou USA	intry?
"neturel, or itams 23a or 28a-f show of cal Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 1 Widowed 4 X Divorced 12. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🎇 No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: wh	, etc.
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if item 27 is marked other then or other treumatic event, the M	٦°	19a. Informant's Name/Relationship (Type, Print) Chris Lehman/son		ng Address (Street a			ity or Town, State, Zi	p Code)
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Evanore Funere	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the bast of examiner: On the basts of examiner and manner stated.	amination and/or is					
Toth	Me	29b. Signature and title of certailer		29c. Licenson		29d.	Date signed (Month)	, Day, Year) 2006
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Amend items 20a c 22 per ffb 2852 2-24-06 yt and Mental Hygiene

Amend Items 25,26 per Dr., C852,02/10/06dbb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:18 AM 30 2006 KOSS 01 John /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MCI-H Infirmani
5. Social Security Number 6. Sex WASHINGTON Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 68 2, 1937 Alabama Director 292-30-8632 Apr Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County 2 should be filed within range and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f anowate avent, tra Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Washington Director MD Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2055, JOHN 21746 USA 18601 Roxbury Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11♥ Never Mamed 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Lee Adkins ပ John Ross Sr traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 11371 Strausser Road Canal Fulton. OH 44614 Sgt Henri Ross/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation • S ☐ Other (Specify) _in_state CRW Crematory 2-14-06 Canton, Ohio Name and REED: FRUNERAL HOME R705 Raffs, Rds. SW 21. Signature of Funeral S. W. Licensee Konald S. Wayde, 22 Name Director 21201 Canton, essal baltimore, MD Approximate Interval Between Onset and Death 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hebatucellulai **Physician** (arunom /Medical Due to (or as a consequence of) Examiner L Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (of as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, in by the funeral director, page 2 should be 40 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 27. Manner of Death Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M hours after death death 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mali 0063383 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ITAGE PSTOWN, MALLIC AKESH Mait 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 1 0 2006

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland	-	rtment tificate				ZIII	6 (3869
	Physic	ian	Decedent's Name (First, Middle, Las Anna Gertrude	7						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City. T	own. or	Location of Deat		Reg: No. Death Day Year 3. Tire (2006) 4c. County of Death Baltimore Cit Birth Day, Year) 4, 1914 Marylan 10d. Inside the Suman of Sum	- 3) - N	
	LAGIIII	iei	970H 2397 A TZ						TIMO			Ac. County of Death Baltimore City 4c. County of Death Baltimore City 9. Birthplace (Sta. Country) 9. Birthplace (Sta. Country) 10d. Inside 1	City
	Funeral Director			ax 7. Ag □ M 2√√ F 9		st birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da Apr 14	th y, Year) 1914	9. Birthp Coun Mary	lace (State or Foreign htry) rland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits
	Maryl	ğ	Maryland Baltimon	~ <u>~</u>		ethor;						1.	1 ☐ Yes 2 ☑ No
	with the Maryland a or 28a-f show Le notified at	Director	10e. Street and Number		1101	CCHOL	10f. Zip C	Code			10g. Citizen o	What Coun	itry?
	th wit	alD	1134 Elm Road				212	227			USA		
	ar dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		5. 13. V	Vas Decede Yes, specif	nt of His y Cubar	spanic Origin? (S n, Mexican, Puer	pecify Yes or No o Rican, etc.)	- 14. Ra		
900	IL Z 12-10-0050 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or itams 23a or 28e-1 show int, the Medical Exarting rought be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	No	1	□Yes 27	No No	Specify:				
<u>u</u>	72 hours "natural"	iete	15. Decedent's Ed (Specify onfy highest gra			16a. Deced	ent's Usual kind of work	Occupa done d	tion uring most of wo	rking	16b. Kind of	Business/Ind	dustry
Ċ	d withing giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		mbler	100100)			Book	Binde	rv
3	filed will Hygiene other the	a a	17. Father's Name (First, Middle, Last)						18. Mother's Na	ne (First, Middle,			-1
	should be nd Mental marksd o	To B	John Blum						Annie F	itzmorri	S		
Monday Stoke	MOTE, MATYIATIO Z ages 1 and 2 should be filed v int of Health and Mental thygie it. If Itam 27 is marked other I y or other traumatic avant, th		19a. Informant's Name/Relationship (7 Delores Ziegler /	• • • • • • • • • • • • • • • • • • • •									Code)
9	s 1 a		20a. Method of Disposition		20b. Pla	ace of Dispos metery, crem	sition (Name	of er place	»)	Date	20c. Location	- City or To	wn, State
	Page Page Tent c		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			raine				/06	Baltim	ore, M	Maryland
9	Dallillore, permit. Pages 1 ar Department of Hea important: if Itam any injury or othe		21. Agnature of Funeral Service Licen	elind	~	41	Name and	Address	s of Facility Hu ns Avenu	bbard Fu e, Balti	meral 1	Home, Maryla	Inc. and 21229
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each li	ne.	Do not ente	2	of dying	, such as cardia	or respiratory ai	rest,		Approximate Interval Between Onset and Death UEEE
3	/Medical Examiner		resulting in death)	a Due to (or as									
L FE	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ence of):							
1- 5	ate be executed thysician and the burial-transit	i Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
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	Los, T.C. Jires that the signed by the detached	d by Ph	Part II. Other significant conditions of	ontributing to death b	_	-		ısə givəl	n in Part I.		1		e cause of death?
GERTRU	e law require has been sig	Completed by	HYPERTER	45[04						24a. Was	sy	prior to con	osy findings available npletion of cause of
W										1 ☐ Yes			2 No
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	Attending Physician: r death. sctor: After this certifica	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 2	R/Outpatient 28b. Time of Injury		c. Injury Work	4 🗀 Nursing F				")
	Witendi death. ctor: A y the fu	icati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		uny - At hom	ne form stre	M factors		es 2 No	28f. Location /5	Street and Num	ther or Pura	I Pouto Number
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	To the Hospital or Attent within 24 hours after deat To the Funaral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best siner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at estigation, in	the time	e, date and place inion, death occu	, and due to the cred at the time,	cause(s) and n date and place	nanner as sta , and due to	ated. the cause(s)
	To the comp	ž	29b. Signature and title of certifier		1				number				
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	H			completed cause of d			A 72	414	ES Ho	SPITAL	BALTIN	NORE,	MB \$ 1229
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 0 200	32 Registra	ar's Signatu	ire for	Se						

	1	For State Registrar	State of Ma	•	artment of Hertificate of L			giene eg. No. 006	03870
Physician	ı	Decedent's Name (First Middle, Last)	NEON				2. Date of Dea Month	th Day Year	3. Time of Death
/Medical Examiner		a. Facility Name (If not institution, give s				Location of Death		4c. County of Dea	th
Funeral		Baltimore Washingt Social Security Number 6. Sex		<u>1 Center</u> (In yrs. last birthday 71 Yrs.	GIEN B If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Anne Aru (5, 1934)	nde I thplace (State or Foreign ountry) Mary I and
Director	J	115-30-3918		10c. City. Town or L	ocation		Aprili	0, 1934	10d. Inside City Limits
Maryla a-f shov		laryland Anne Arur		Pasac					1 X Yes 2 □ No
with the Mar a or 28a-1 s be mulled	1	0e. Street and Number			10f. Zip Code 211	22	1	10g. Citizen of What C USA	ountry?
death	1	866 Swift Road 1. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		
036 ours after ral, or its		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1□Yes 2᠒No	Specify:			hite
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Mental Hygiene and Mental Hygiene and Mental Hygiene and Mental Hygiene and Mental Hygiene and I have a so the standard of the standard in the Hygiene and Boogle. To Re Completed by Funeral Director		15. Decedent's Educ (Specify only highest grade		(Giv	edent's Usual Occupi e kind of work done o DO NOT use retired	turing most of work	ing	16b. Kind of Business Unio	
be filed vital Hygie of other is event, it	3	7. Father's Name (First, Middle, Last)			Teamster	18. Mother's Nam	e (First, Middle,		I.I.
faryland	2	Patrick Scar		19h Mai	ling Address (Street		stisia al Boute Numbe	Smith r, City or Town, State,	Zip Code)
P, Mai	-	Marguerite Scar			Swift Ro				122
more, Maryla Pages 1 and 2 should nent of Health and Men in: If them 27 is marke in: or other traumatic	12	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Disp cemetery, cri	position (Name of ematory or other place	e)	Date	20c. Location - City of	White Bottom
Baltimori permit. Pages Department of I Importent: If Its any injury or o once.	ŀ	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	6/11		11 Cemete 22. Name and Addres			6 Baltimo Funeral H	
Balt permit. Departr Importe any inju		Muschell h	allen	2) 3	8111 Mount	ain Rd, F	asadena	, MD 21122	Approximate
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/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	D				
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8760, cate be executed physician and the burial-transit	Lyg	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
cate be ex physician the burial	2		J						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	- Jaiotai ji Mo	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy	,		23d. Date of do Month	elivery Day Year
ds, P.(בר '	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.		obacco use contribute	to the cause of death? Probably 4 □Unknown
Il Records, The law requires to cate has been signe page 2 should be	niihier							an 24b. Were a prior to death?	
/ita	מ	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea			
hys his his light		1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injur	4 Nursing H		dence 6 Other (Sp now injury occurred	ecity)
Division of Attending after death. Director: After din by the fune	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, farm, : :. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	eatcal	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred at the tir investigation, in my c	ne, date and place, pinion, death occur	, and due to the orred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To th within To th compl		29b. Signature and title of certifier	100		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
h		30. Name and address of person who co	empleted cause of de	eath (Item 23a) (Typ		21336	1	2/9/00),
		HUBIN O. KNY	MY MD	8028	RITCHIE	twy, su	ATE 134	PASADEN	A, MZIIZZ
State Registra		31. Date filed (Month Bay1 Yelf) 200	6 Registra	ars Signature	MARIE .				

			1 - For State Registrar	State of Marylar	•	ment of H		Mental Hygie	2006	03871
	Physici /Medio		1. Decedent's Name (First, Middle, Las Charles Francis					2. Date of Death Month Feb. 8,	Day Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, given 1807 Meadow Lar			b. City, Town, or ibson I:	Location of Death	1	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. S		last birthday) 1	Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 10/9/193	ar) 9. Birth	pplace (State or Foreign intry) Vland
	ehow	'n	Usual Residence of Decedent 10a. State 10b. County MD Anne Ant		ty, Town or Locati			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the M a or 28a-1 be notifi	Director	10e. Street and Number 1807 Meadow Lane	ander urb		10f. Zip Code 21 056			Citizen of What Cou	
936	72 hours after death with the Maryland 'naturel', or Iteme 23s or 28s-1 ehow dical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:				pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 Ie marked other then "natural", other traumatic event, the Medical Exi-	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give kin	NOT use retired)	luring most of wor	king 16b	. Kind of Business/l	ndustry
yland 2	2 should be filed and Mental Hyg le marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last) Charles F. Stein,		770007110			ne (First, Middle, Maid enneburg		
e, Mar	1 and 2 sho Health and tem 27 le m		19a. Informant's Name/Relationship (1) Ann Stein/Spouse		Topowers were	oadow La		ral Route Number, Cit Soti Island Date 20c.	THE SHEET OF	- 3
timor	permit. Pages I Depertment of F Important: If Ite any injury or ot ance.	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cremato cro Crema	ory or other place TONY	2/9/		ltimore,	
Bal	Depermine trapole trapole eny irrespondent	l ()	21. Signatur of Fune a Service Lice	+ 1	31	ame and Addres	St tain Pd	allings Fu , Pasadena	neral Hom	2
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions,	a. CHRO1 Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	UIC R uence of): YELI	ESPIR	SINCE	GAIC D	URE HOOS.	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq c						
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on of	ding Pt h. After th funeral	itlon: To	27. Manner of Death 1 Manural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Iturality II	ome 5 Residence 28d. Describe how in		ny)
Division	• Hospital or Attend 24 hours after death • Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street,	factory, office		28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or Attenwithin 24 hours after dealing to the Funeral Directors completely filled in by the	edical	(Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death oc tion and/or invest	curred at the time igation, in my op	e, date and place inion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
)	Tor	Σ	29b. Signature and title of certifier	L		29c. License			B., 9, 2	
	10		30. Name and address of person who o	A. YAS		100 1	nemo	RIAL H	ESPITAL	006 BSIZMIN
	Sta Registr		31. Date filed (Month Pay Year) 2	006 32. Registrar's Signa	iture.	di)				

			1 - For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene leg. No.	06	0387	12
50	Physici	an.	Decedent's Name (First, Middle, La	,							Date of Dea Month	Day	Year	3. Time of D	Death
	/Medic		Walter C. Sch		•						Februar	1	2006	1645	М
	Examir	ner .	4a. Facility Name (If not institution, give				4b. City,		Location of	of Death		4c. Cou	inty of Death		
3,5		30 m	Montgomery Ge 5. Social Security Number 6.3		ital e (In yrs. las	t hirthdayl	If Under		ney	24 Hrs	O Date of Rive		ntgome		<i>E</i>
	Funeral Director			1 ☑ M 2 ☐ F	86	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sept. 19	, 1919	9. Birth Cou Wis	place (State or intry) CONSIN	Foreign
	land		10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City	Limits
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	28a	rec	10e. Street and Number	nery			10f. Zip		2			10g. Citizen	of What Cou	ntry?	
	3a o	Funeral Directo	15301 Barningh	am Court				2090	6			Unit	ed Sta	tec	
	deetl me 2	ner	11. Marital Status	12. Was Decedent B	Ever in U.S.	13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri	can Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Interportant: If term 27 is marked other then "naturel", or iteme 23a or 28a-1 ehow eny injury or other traumatic event. It a Medical Examinar manual te notified at ance.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		1 ☐ Yes		n, мехісап Specify:		Hican, etc.)	1	Black, White ecity: W	hite	
9	72 ho	ted	15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occupa	ation	t of work		16b. Kind o	f Business/Ir	ndustry	
21	en e	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of wor DO NOT us	se retired)	LOI WOIKI	ing				
7	ed wi	S					C	hemi					M.I.H.		
nd	d oth	Be	17. Father's Name (First, Middle, Last								First, Middle,		name)		
Χ	Men Merke arke	၉	Charles Schneid								a Neuen				
a	2 sh and is m		19a. Informant's Name/Relationship	**							al Route Numbe	-			
<u>~</u>	and lealth m 27		Edith M. Schneide	r/Wife	201 01-						, Silve)
altimore, Maryland	ges tot H ite		20a. Method of Disposition 1 🗆 Burial 2 🖫 Cremation 3	Removal from State	Mont	etery, crer Some	natory or o	ne of ther place	e) Fe	ebrua	ry 8,		on - City or T		
Ē	men tant: jury		4 □Donation 5 □ Other (Speci	4)	Crem	nator:	ium,			200				aryland	
Baj	Depermit Deper impor eny in		21. Signature of Funeral Service Lice	MO13	386	Ro Ro	Name an Ockvi Ockvi	d Addres	Inc. Mary	y Rob 300 1and	ert A. West M 20850-	Pumphi ontgon 2805	rey Fu nery A	neral H venue	iome/
1	Physician /Medical Examiner		23a. Part1. Enter the disease, of eon shock, or heart failure. List only trimmediate Cause (Final disease or condition resulting in death)	a. Pho	the death. ie.	omo	er the mod	e of dying	g, such as	cardiac (or respiratory are	est,		Approximate Interval Betwo Onset and De	reen
8760,	death certificate be executed e ettending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to minimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
.O. Box 6	that the death certific led by the ettending pl detached for use as t	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. tf yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	ath 3	Ectopic pr Other (sp					1	Date of deliv Month	,	9 ar
٥.	The law requires that the tee has been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death bu	ıt not resultir	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to t	he cause of de	ath?
Records,	puires ngr raigr	d by	Malnutritio	N							1 🗆 Y	es 2 No	3 🗆 Prol	bably Au	fiknown
Ö	w require been si should b	Completed									24a. Was a	n 24	h Wara aut	opsy findings av	vailabte
Re	he lav s has ge 2	E									autops	ged?	prior to co death?	impletion of cal	use of
			25. Was case referred to medical		_							No.	1 🗆 Yes	5000	
Vital	Physicien: The this certificate har ral director, page	o Be	examiner?	Hospital:				Othe			Check only or				
ō	Phys rthis raldii	-	27. Manner of Death	28a. Date of Injur		VOutpatien		- A	4 LI NU		me 5 Resid			fy)	
0	ding f th. After funer	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	8c. Injury Work 1 □ 1	? ⁄es 2 □ !			()			
Ś	i or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not be determined	e 39a Place of this	iry - At home . (Specify)	e, farm, str	eet, factory	r, office			28f. Location (S City or Tow		mber or Run	al Route Numb	Θ <i>r</i> .
	To the Hospitel or Attending Phywithin 24 hours attended in within 24 hours attended in to the Funeral Director: Alter the completely filled in by the funeral	edical C	29a. Certifier Check only one) 2 Medical Example 2	nysicien: To the best of miner: On the basis of and manner sta	examination	edge, death and/or inv	occurred restigation,	at the tim	e, date and pinion, deat	d place, and the occurrence	and due to the c ed at the time, d	ause(s) and ate and plac	manner as s ce, and due t	stated. o the cause(s)	
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	7			290	. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
			→ / / / / (Kin-	- W		-	DO	563	190	9	2/11	06		
	.0		30. Name and so e s of vison who	completed cause of de	eath (I em 23	За) (Туре,						1 1	,		
	10		Matthew C. Mrs	rud vew	1810	1 Pri	nce	PWI	ip [oriv	7 O(v	voy,	MD	3083	32
300	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Registra	r's Signatur	9			•			,			

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Rodney Shaw February 2006 7:43 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8865 Blue Sea Drive Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 10 1918 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) 88 Yrs. **Funeral** Birthplace (State or Foreign Country)
 AD 431-09-0900 Director Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits N/A N/A Director Washington, D.C. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 2 3050 Military Road, NW, Apt. 240 20015 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after rands of Healin and Mental Hygiene.

Int: If flom 27 is marked other than "natural; or flat into or other traumatic event, the Medical Experimenty or other traumatic event, the Medical Experiment Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No à Specify: 3 Nidowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Non-Profit College (1-4or 5+) 5+ Elementary/Secondary (0-12) Organization Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Waite Shaw Pearl Eliza Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerri Lea Shaw - daughter 8865 Blue Sea Drive, Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/7/2006 Beltsville, MD 21. Signature of Funeral Service License Rapp Funeral and Cremation Services 933 Gist Avenue, Silver Spring, MD M00986 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** scase disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death P.O. I 5 Other (specify) ete has been signed by the a page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Vas 2 No certificete 1□ Yes After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Lone specify 1 ☐ Yes 2 No ပ္ To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medi 29b. Signature and title of certifier 29c. License number Fe bruary 6, 2006 no

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

St. Balto md

cause of de (I -m 23a) (Type, Print)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Month 02 06 06 2006 08:05p M William Guy Suter 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 82 Months Days Hours 12000 MM 2 □ F Yrs. 194-14-8237 05-05-1923 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2X No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 USA 333 Russell Av Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status tx□XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes XXNo Specify. 3x53Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Book Publishing Publishing Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Melissa Marvin Clement Guy Suter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1655 Harvard St. NW Washington DC 20009 Kathryn Suter/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Uniform Services of 1 Burial 2 Cremation 3 Removal from State 02-07-2006 Bethesda, MD 4 ☑Donation 5 ☐ Other (Specify) the Health Sciences 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Ser. 933 Gist Av Silver Spring MD 20910 mo 1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Recurrent Pneumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2x No 26. Place of Death (Check only one)

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

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Certification: To

Medical

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29a. Certifier

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked oth ery liquy or other treumatic event 2008:

Physician

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Director

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Funeral

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28a-1 ehow

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e filed within 72 hours after. If Hygiene. other then "natural", or Itel

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

signed by the attending physicien and d be detached for use as the burial-transit

law requires that the death certificate be executed this certificate has el or Attending Physicien: T s after death. I Director: After this certificat To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funarel Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760.

State

25. Was case referred to medical examiner? Hospital: Other: 1xx es 2 No 1 I fnpatient 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6 QOther (Specify) Hospice 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

02-06-2006

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Charles Harrison MD 6001 Muncaster Mill Rd. Rockville MD 20855

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 2 2006 4c. County of Death Month **Physician** Dorothea G. Starkey tebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X Yrs. Director 217-22-2914 May 5, 1926 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Md. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Williams Street 21014 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ No Specify: Specify: white If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) homemaker ll years own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry C. Greve Mildred N. Koedler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Ie rr any Injury or other traum 2002. Wayne Starkey/son 116 Williams Street, Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns 2/6/06 Timonium, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Dea 23a Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final metastatic Priysician Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the ettending physicien Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the ette page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has төо? 2 X No 1 ☐ Yes Be (25. Was case referred to medicat 26. Place of Death | Check only one examiner? 1 ☐ Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) tsh Kan Bahrani, m.D. 6025. 32. Registrar's Signature State FEB 1 0 2006 Registrar

rtarKey, Dorothee #025732

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 5, **SPERANDEO** 2006 1:45 P. M. LENA J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FOREST HILL FOREST HILL HEALTH & REHAB CENTER HARFORD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | March 27, 1913 | Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2□ F 216-01-6977 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No Director Md. Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 U.S.A. 300 W. Ring Factory Road, No. 206A Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? □Yes 2 No Yes, Give 1 Never Married 2 Married white 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Lebow Bros. Clothing 15. Decedent's Education (Specify only highest grade completed) Mfg.) clothing Elementary/Secondary (0-12) College (1-4or 5+) tailor 8 years
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simone Cirincione Rosolia Missineo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47 Crystal Court, Bel Air, Md. 21014 Anthony Sperandeo/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Most Holy Redeemer Cem. 2/8/2006 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. Part1. Enter the disease, or connections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown n signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an certificate has autopsy performed? Yes 283 No. 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: And Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Davil February 6, 200 L 032255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR, MD. 615 W. MACPHAIL ROAD 21014 DR. DAVID DUNN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

MARY SENEY 06-0912 adh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N e <i>rtificate of Death</i>	nental Hygie Reg.	2000	03877
	Physici		1. Decedent's Name (First, Middle, Last) Mary Katherine Seney		2. Date of Death Month FEBRUARY	Day Yea 5, 2006	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	TEDICITIE	4c. County of De	
			FRANKLIN SQUARE HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ROSEDALE v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMO	
	Funeral Director		141-22-7697 ^{1 □ M 21} 80 Yrs.	Months Days Hours Min.	Nov. 14,	1925 Ma	irthplace (State or Foreign Country) aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	·		10d. Inside City Limits
	e-f eh	ctor	Maryland Baltimore Parkvi	11e			1 ☐ Yes 2 ☐XNo
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What	*
	eath w	erai	8800 Walther Blvd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21234	acifu Vac or No-	U.S.A	nerican Indian,
٥	72 hours after death with the Maryland "natural; or iteme 23a or 28e-f ehow edical Examination multiput at	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Wi	
3-003p	ural', c	d by	3 ☐ Widowed 4 ♣ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ X No Specify:		Specify:	White
7	in 72 t	ompieted	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ing 160	b. Kind of Busines	ss/Industry
7 7	d within giene.	mo	Elementary/Secondary (U-12) College (1-4or 5+)	Homemaker		Own Hor	me
	be filed Ital Hygi Id other avent, I	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	,	
<u> </u>	s 1 and 2 should be filed I Health and Mental Hyg Itam 27 is marked othe other treumatic avent,	၉	George A. Bratt, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Mildre		ipley	Tin Co. do.)
2	and 2 s salth an n 27 is i				Phoenix, N	•	21131
e,	of Health of Health litem 27		20a. Method of Disposition 20b. Place of Dis			. Location - City	
altimor	Page ment ant: if ury or		4 Donation 5 Other (Specify)	Service Corp. 2-8-		Towson, N	
מו	permit. Pages 1 Department of H Important: If its any injury or ot						Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		TOWSON, Mo		21204 Approximate Interval Between
	Physician			Meroscleraticcord		0	Onset and Death
	/Medical		disease or condition resulting in death) a	16103CIE!DITCOSCI	10 Vascines	C112652C	
	Examiner	_	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying b				
+	uted d ansit	Examiner	Cause. Chief Undertying Cause (Disease or injury that initiated events c.				
Š	en and	Exa	resulting in death) Last Due to (or as a consequence of):				
09/90	ificate be executed g physicien and as the burial-transit	edicai	d				
	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of d	elivery
. DOX	ie law requires that the death certii has been signed by the attending pe 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No Understand death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
г Э	requires that the	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	na dankina na na na na ia Bandi	220 Did tehan	an was anatábuta	to the source of death?
Ď,	uires ti signe Id be c	d b	Part II. Other significant conducties contributing to death but not resulting in the	underlying cause given in Fart I.	1 ☐ Yes		to the cause of death? Probably 4 Únknown
Solds	law req as been 2 shou	iete			24a. Was an	24b. Were	autopsy findings available
ב ב	The la	Completed			autopsy performed	1? death	
E a	cian: ertific ector,	Be (25. Was case referred to medical examiner?	0.0	h (Check only one)		
5	Physic rthis c	2	1 Yes 2 No Hospital: 1 ☐ Inpatient 2 XEP/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time		me 5 Residence		pecify)
VISIOIS	nding nth. r: After e fune	ation	1. Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Tyes 2 No	200. 200020 11011	injury occurred	
<u> </u>	r Atter ter des frector	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S		Rural Route Number,
2	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de				
	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2X Medical Examiner: On the basis of examination and/or and manner stated.	arn occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the To the comp	ž	29b. Signatore and title of cartifier	29c. License number		Date signed (Mo.	
			Tate Chance-Tollare	o OCME	F	EBRUARY (6, 2006
	15		30. Name and address of person who completed cause of death (Item 23a) Typ	9, Print)			
ľ	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	C			
	Registr	ar	FEB 1 0 2006				

			1 - For State Registrar	State of M	aryland		rtment tificate			ind Me		iene	5	03878
3	Physici		1. Decedent's Name (First, Middle, Last) Gladys A.	Spic	knall						Date of Deat Month CDTUAT		ŬĞ	3. Time of Death 12:30 p M
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, To	own, or l		f Death		4c. County		ore
VA: 7	Funeral Director	20.00	Social Security Number 6. Sex	7. Ag	e (In yrs. Ia B5	st birthday) Yrs.	If Under 1		If Under 2 Hours	Min. AL	Date of Birth (Month, Day, ID 26,	1920	_Cou	place (State or Foreign ntry) BNCE
	Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD Balti	more		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Director	10e. Street and Number 1055 W. Joppa Rd.				10f. Zip 0	²⁰⁴			10	og. Citizen of W		ntry?
36	s after death , or itama 23 aminar mus	by Funerai		2. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		li li		nt of His y Cuban	spanic Orig , Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		k, White,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or itama 23s or 28e-f ehow raumatic event, Ire Medical Examinat must be notilised at	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation	5+)	lite. L	ent's Usual kind of work OO NOT use	done du retired)	uring most	of working		16b. Kind of Bu		dustry
nd 2	be filed v tal Hygie d other t event, In	Be Co	17. Father's Name (First, Middle, Last)			<u>!</u> .	unema				First, Middle, N	Maiden Sumam	9)	Jille
aryla	should that the should	To	Charles W. 19a. Informant's Name/Relationship (Type	Ander	son	19b. Mailin	g Address (Street a		nee r or Rural R	Route Number,	Such		Code)
e, M	ges 1 and 2 should it of Health and Men it frem 27 is marke or other traumatic	,	Annette Kubinec-da	ughter	20b. Pla	ace of Dispo	aton (Name	9 of		an, No		20c. Location -	City or T	own, State
altimore,	Pages nent of thint: If its		1 X Buriai 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cei	metery, cren Olive	natory or oth	ner place		2/11/		Freder	•	
Balt	permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service License	⊛ William	G. Da						Towson on, MD	Funera 21204	ıl Ho	ome, Inc.
+	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events	Due to (or as	hrova a conseque	ence of):						sst,		Approximate Interval Between Onset and Death 10 days 30 years
.O. Box 68760, ~	The law requires that the death certificate be executed site hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as	of pregnan	icy death 3	Ectopic pre					23d. Date Mor		ery Day Year
۵.	ires thet the signed by t d be detach	1 by Phy	Part II. Other significant conditions con	4			nderlying car	use give	n in Part I.					he cause of death?
Division of Vital Records,	The law require hes been hage 2 should	Completed by								<u> </u>	24a. Was ar autops perform 1 Yes 2	y ned?/	rior to co	opsy findings available ompletion of cause of
Vital	ician: certifice ector, p	Be	25. Was case referred to medical examiner?	ospital:				Othe			Check only on			
on of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: Atter this certificate he completely filled in by the funeral director, page	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		Proutpation 28b. Time of Injury		ic. Injury Work	4 (1) INUI	28		nce 6 Other		fy)
Divisi	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At hor tc. <i>(Specify)</i>	me, farm, str	eet, factory,	office		281	Location (St. City or Town		er or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Direction completely filled in I	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best ner: On the basis of and manner st	of examination	vledge, death on and/or inv	occurred a restigation, i	t the tim in my op	e, date and inion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) and mai ate and place, a	nner as s ind due t	stated. to the cause(s)
)	To th within To th сощр	Me	29b. Signature and title of certifier	Mun	fere	1			number 410)		2/6/		
	10		30. Name and address of person who con 10 755 Fc()	mpleted cause of	Lut rar's Signati	23a) (Type, her vi	Print)	YD,	210	093,	Lau	ra M.	M	umford, Mil
	Sta Regist		31. Date filed (Montin, Day, Fear)	A.	ar a aigirall	le de	30/2)							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month FEBRUARY Day Vasi **Physician** Ruth Moore Smi th 8. 2006 04:11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Towson Baltimore If Under 1 Year If Under 24 Hrs. A. Date of Birth (Month, Day, Year) Aug. 14, 1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ XF 218-28-4957 74 Maryland Director Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10h County 10a State th and Mental Hygiene. If is marked other then "natural", or items 23a or 28a-f ehov traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 XNo Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than any highry or other traumerical. with 1 413 Ivy Church Road 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Employee Benefits 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Moore Effie Norris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Gilbert R. Smith/Husband 413 Ivy Church Road Timonium, Maryland 21093 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dulaney Valley Mem. Grd. 2/11/06 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner attanding physicien end for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. PNEUMONIA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 X No 3 Probably 4 Unknown 1 Tes **HEMOTHORAX** ATRIAL ARRHYTHMIAS 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No this certificate 1☐ Yes ANEMIA After this certification funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 WNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 | Pending To the riversities death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MT 29c. License number 2-8-06 TICHLY D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM, M. D. 7601 OSLER DRIVE TOWSON, MARYLOND 21204 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registra FEB 1 0 2006

Amend item#18,20b, perfH,0852,2/10/06 IT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY **Physician SUGHAR** 5, 2006 10:30 P [™] IDA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME 8. Date of Birth (Month, Day, Year) MAR. 17, 1907 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 213-34-4152 98 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28s-1 ahow permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if item 27 Is marked other than "natural", or Items 23a or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 □ No To Be Completed by Funeral Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 3807 SEVEN MILE LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes, Give Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** GENERAL CONTRACTOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) KRAUSE DORA -AFROMFICH ISRAEL Afromofich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7370 S. ORIOLE BLVD. #804 - DELRAY BEACH, FL 33446 LINDA SPITALSKY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/9/2006 1 Burial 2 Cremation 3 Removal from State BETH ISAAC ADATH ISRAEL 2/2006 DUNDALK, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) hurs Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 I ive birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions confirmbuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗍 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the hosping after death, within 24 hours after death.

To the Funerel Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) FEB 1 0 State 10 2006 Registrar

1 - For Stata Registrar

10a State

MD

11. Marital Status

SOLOMON

20a. Method of Disposition

5. Social Security Number

10e. Street and Number

214-44-6511

Usual Residence of Decedent

7600 CARLA ROAD

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 🕽 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: if item 27 is marked other then "natural", or iteme 23e or 28e-f show sup injury or other fraumatic event, the Medical Examinant be notified at once.

1. Decedent's Name (First, Middle, Last)

TOBI

STELLA MARIS HOSPICE

10h Counts

4a. Facility Name (If not institution, give street and number)

1 □ M 2 🕡 F

BALTIMORE

15. Decedent's Education (Specify only highest grade completed)

ELNORA FRIEDLANDER / MOTHER

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		shock, or heart failure. List only	one cause on each line.		,			Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CONGESTIVE		URE			Onsor and Estativ
Examiner	İ		Due to (or as a consec	quence of):				
be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consecutor) Due to (or as a consecutor)					
physicia the bur			d					
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🇷 No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	al death 3 □Ectopic	c pregnancy (specify)		23d. Date of del Month	ivery Day Year
uires that ti i signed by Id be detac	É	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.			the cause of death?
	Completed					24a. Was an autopsy performe	d? prior to death?	itopsy findings available completion of cause of
certifical	Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
Physic this ce at direc	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing I	dome 5 Residence	e 6 X Other (Spe	city) HOSPICE
or tree	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	i i	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
al or Atters after de ni Directo	Sertific	3 Suicide 6 Could not be determined		iome, farm, street, fact fy)	tory, office	28f. Location (Stree City or Town, S	et and Number or Au State)	ural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical (nysician: To the best of my knominer: On the basis of examination and manner stated.					
Nithir To th	ž	29b. Signature and title of certifier			29c. License number	29d	. Date signed (Mont	h, Day, Year)
		12-			D43725		2/8/0	6
10		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)			. ,	
		DR. TARIQ MAHMOO	DD 2300 DULANI	EY VALLEY	RD. TIMONIUM	, MD 21093		
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 0	32. Registrar's Signal	ature				
MH 17 Rev 1/20	01		A STATE OF THE STA	AT A STATE OF				
				ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

SILVERBERG

If Under 1 Year

10f. Zip Code

1 ☐ Yes 2 🕅 No

21208

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Days

Months

BALTIMORE

LAB TECH

FRIEDLANDER

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

HAR SINAI CEMETERY

7. Age (In vrs. last birthday)

10c. City, Town or Location

62

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

State of Maryland / Department of Health and Mental Hygiene

4b. City, Town, or Location of Death

TIMONIUM

If Under 24 Hrs. Hours Min.

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

ELNORA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

02/09/2006

03881

1:30

Birthplace (State or Foreign Country)

USA

WHITE

RAFF

JOHNS HOPKINS HOSPITAL

3. Time of Death

BALTIMORE

NC

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

AM

Reg. No.

FÉBRUARY 8, 2006

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

SOL LEVINSON & BROS., INC.

OWINGS MILLS, MD

14. Race - American Indian

Black, White, etc.

2. Date of Death

8. Date of Birth OCT. 8, 1943

18. Mother's Name (First, Middle, Maiden Sumame)

3800 S. DECATUR BLVD. #242 - LAS VEGAS, NV 89103

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

DHMH 17 Rev 1/2001

2006

6,

FEBRUARY

TERMANI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last), 2. Date of Death **Physician** 20300M 4c. County of Dear /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hesapeake 5. Social Security Number Sex (ast birthday) If Under 1 Year If Under 24 Hrs. Firthplace (State or Foreign yrs. Funeral Months Days Hours Min. 1 M 2 F Director Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "neturel", or Iteme 23a or 28e-f show other treumetic event, the Mudical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? USA 21 Completed by Funeral Was Decedent Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Black, White, etc. 2/4/06 2030 PM 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Whit 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) icia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) Important: if Item 27 is any injury or other treum 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licence 22. Name and Address of Facility uneral chapel-23a. Part1. Enter the disease, of shock, or heart failure. List Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause Final disease or condition resulting in death) and Death Physician tour. /Medical Due to (as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 1 Yes 2 No 3 No of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospitel or Attending 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📙 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician GILBERT 14 33 M FERRUARY 06 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-32-9256 Director Feb. 2,1935 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow in than "naturel", or items 23s or 28s-f ehore the Medical Exeminar must be notified at Md. Baltimore Dundalk 1 □ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2015 Bear Ridge Rd. Apt. 104 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: 3 SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic American Nath. Can 4 yrs. Ith and Mental Hygie 27 is marked other r treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Tutin Katherine Wieczorek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i Margaret Tutin wife 2015 Bear Ridge Rd. Dundalk Md. 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. Date 10, 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: if eny injury or once. Bayview Crematory Baltimore 2006 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility. Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do go enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner CARDIOM YORATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit the death certificate be executed Polmona
Due to (or as a co sequence of): Physician/Medical use as ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۵ cete hes been sign. page 2 should t RENAL INSUFFICIENC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown OBESIT 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No of Vital 1 Yes 2 No : After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division s after dea. 1 Natural 5 Pending Injury 2 Accident investigation 1 TYes 2 TNo 3 ☐ Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

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nd address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

29d. Date signed (Month, Day, Year)

29c. License number

February 9, 2006 Baltimore Maryland 21287

Robert Stephens MD Johns Hopkins Hospital 600 North Wolfe Street

State Registrar 31. Date filed (Month, Day, Year) FEB 1 0 2006 32 Registrar's Signature

			For State Registrar	State of I	Marylan		artment of F				jiene	0.6	03885
		113	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	th	is new con-	3. Time of Death
10.50	Physici /Medic		Margaret Jeann	e Tenley						Month Februar	y 8,	2006	4:50 P M
	Examir		4a. Facility Name (If not institution	-			4b. City, Town, o	r Location	of Death		-	County of Death	
			707 Maiden Cho				Catonsv					ltimore	<u> </u>
В	Funeral		5. Social Security Number 220-07-3329	6. Sex 7. 1 ☐ M 2 🗓 F		last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		91	115.				Nov. 6,	191	4 New	York
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mar	tor	Maryland Balti	more		Catons	ville						1 ☐ Yes 2 ☑ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			1	Og. Citize	en of What Cou	intry?
	23a (ai	707 Maiden Cho	ice Lane A	pt.711	.1	2	1228			USA	A	
	teme teme	nue	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	.S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	igin? (Spe	cify Yes or No- Rican, etc.)	14	Race - Ameri Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 🏋 Widowed 4 ☐ Divorced	If Yes, Give	_		1 ☐ Yes 2 ☑ No	Specify:		. ,	s	Specify: Wh:	
21215-0036	filed within 72 hours after death with the Maryland Hygiene Han "natural", or Iteme 23a or 28a-f ehow oth, Ire Medical Exantice in the Ire Irelified at	ed b	15. Decedent	Year or Date	s:	163 Dogg	dent's Usual Occup	ation		· · · · · · · · · · · · · · · · · · ·			
5	in 72 n "na nedic	Completed	(Specify only highes	t grade completed)		(Give	kind of work done DO NOT use retired	during mos d)	t of workii	ng	16b. Kind	d of Business/Ir	ndustry
212	d with	mo	Elementary/Secondary (0-12)	College (1-4c	or 5+)		acher				Educ	ation	
פַ	othe vent,	BeC	17. Father's Name (First, Middle, I	_ast)				18. Mothe	er's Name	(First, Middle,			
<u> a</u>	Venta Venta rrked	To E	Sylvester Hard	ing					Luci	lle Ride	er		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department if the Z1 is marked other than "natural; or theme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examination and Legical and 20ce.		19a. Informant's Name/Relationsh	, , , , ,		19b. Mailir	ng Address (Street	and Numbe	er or Rura	l Route Number	, City or	Town, State, Zij	Code)
≥,	and ealth	6.5	Joseph P. Morga	an/ Grandso			Winners		Le, B	elcamp,	MD :	21017	
ore	I of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from Sta			sition (Name of natory or other plac		Febru	ate lary	20c. Loca	ation - City or To	own, State
altimore,	. Pag Imeni tant: jury		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Cro		le Vet.						, Maryland
Bai	ermit Depar mpor my in		21. Signature of Luor al Sirvi	icen ee	240129	22	Name and Addre	ss of Facilit	ySter	rling As	shton	Schwal	Witzke
	40204		7			16	Funeral 30 Edmon	dson	Aveni	ie; Cato	nsvi	lle, MI	
. *			23a. Part1. Enter the disease, or shock, or hear failure. List of	omplications that caus	ine.	1. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
· 22	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		2000								
	Examiner			Due to (or a	as a consequ	uence of):							
	*	e	Sequentially list conditions, if any, leading to immediate	b Due to (or a	as a consequ	uence of):							
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
v O	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequ	uence of):							
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	cal		d									
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Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐Live birth			Ectopic pregnancy				23	d. Date of delive	
0.	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown			Other (specify)					Month	Day Year
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		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		FB/0	3 DOA Cthe			Check only on			
	y Phys ar this aral di	\vdash	27. Manner of Death	1 ☐ Inpa 28a. Date of In (Month, L		ER/Outpatien 28b. Time of	28c. Injun	4 140		8d. Describe ho			(y)
DIVISION	Attending ir death. ector: After by the funer	ation	1 Natural 5 Pending		Day Year)	Injury		<br Yes 2∐t			,,		
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5	s after s afte	Certification:	- I tollicas	building,	etc." (Specify	"				City or Town	, State)		
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in E	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the bes xaminer: On the basis	of examinat	wiedge, death	occurred at the tim	ne, date and	d place, a	nd due to the ca	use(s) ar	nd manner as s	tated.
	within 2 within 2 To the I	Med	0.1.07	and manner	stated.								
,	T vit	-	29b. Signature and title of certifier		(29c. License			29	ed. Date s	signed (Month,	Uay, Year)
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	10		30. Name and address of person w	no completed cause of	death (Item	23a) (Type, I		Ol.	: a =			J	
332 6	Sta	e	31. Date filed (Month, Day, Year)	32. Redis	strar's Signat	nte	biden	Ch	SICE	ru C	and	BALLIE	CMD
	Registra	_	-	0 2006	River -	A A	mile						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat 03886 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day VEREEN 1255 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bon Secour 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07-24-1913 Birthplace (State or Foreign Country) **Funeral** 1□M 2<mark>X</mark>F 250-30-7917 92 Director South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be notified at Director 1X Yes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1000 Gilmor Street 21217 Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or hearth injury or other treumeting. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lily Bowden Robert Bowden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Brown/ Granddaughter 2477 Ardmore Manor Winston-Salem, NC 27103 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2-15-06 Little River, SC Lee Crematory ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ (Month own 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? @No 1 Yes 2 □ No 1 ☐ Yes Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 ☑ No 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Matural 5 Pending death. 2 Accident investigation 1 Tes 2 No 24 hours after deat Funerel Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide filled in 29a. Certifier 12 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye My AN Year) Registrar's Signature State 0 2006 Registrar

				1 - For State Registrar	State of Mary			of Death	wentar riy	Reg. No.	IU	00007
		Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of De	Day	Year	3. Time of Death
		/Medic		Mary Ann Wright					February	4 2	006	5:30 P M
		Examin	er	4a. Facility Name (If not institution, s BAITIMORE WASLINGTH		her		wn, or Location of Deat Bur Nie	h	4c. County		اماس
		Funeral			. Sex 7. Age (In)	yrs. last birthday) If Under 1					place (State or Foreign otry) / land
		Director		212-32-6876 Usual Residence of Decedent	1□ M 2XIF 70	O Yrs.			9/6/1	935	Mary	/l'and
	death with the Maryland	how		10a. State 10b. County	10c	. City, Town or L	ocation				1	0d. Inside City Limits
_	e Ma	8a-f e	Funeral Director	MD Anne Ar	undel F	Pasadena						1 Yes 2 No
MARY	with th	a or 2	Dire	10e. Street and Number	d		10f. Zip Co	1122		10g. Citizen of V	What Cour	ntry?
Σ	death	ms 23	nera	8462 Church Roa 11. Marital Status	12. Was Decedent Ever i	in U.S. 13.		t of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or N			can Indian,
Wright,	ours after	Department of Health and Mental Hygiene. Imcorfant: If Item 27 is marked other then "natural", or items 23s or 28s-f ehow en, in ury or other traumatic event. The Madical Examiner must be notified at ones.	1 by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			No Specify:	to Hican, etc.)		ck, White, /: Whit	
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7		al Hyg	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Na		, Maiden Surnan	10)	
2	y la	Ment narked natic	10	Joseph A. Guzin					d Lynwi		A	
Z	Mass dass	Ith and 27 le n traun		19a. Informant's Name/Relationship Thomas L. Wrigh				treet and Number or Ri dale Ave.,				Code)
Palimore Menyland	s lar	Item other	i	20a. Method of Disposition	20	Db. Place of Disp			Date	20c. Location -		own, State
Ě	Pag	ant: M		t ØBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Soe	city) M1	t. Carme	el Metho	odist 2/9	/2006	Pasaden	a, MC)
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			V V	23a. Part1. Enter the disease, or co shock, or heart failure. List on	imple ations that caused the cally of each line.	death. Do not er	nter the mode o	of dying, such as cardia	or respiratory a	arrest,		Approximate Interval Between Onset and Death
		ysician Medical		Immediate Cause (Final disease or condition resulting in death)	Alcoho		-iver	Disease			-	
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0	. ŏ	/ the ettendir ched for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic preg □ Other (speci			1	te of delive nth	ery Day Year
	-	signed by the e	by Ph	Part II. Other significant conditions	s contributing to death but not	t resulting in the	underlying caus	se given in Part I.	23e. Did	tobacco use cont	ribute to th	ne cause of death?
3 M	requires	should t	ted						10	Yes 2 No	3 Prob	ably 4 Unknown
~ a	_ #	n. After this certificate has b funeral director, page 2 st	Completed						24a. Was auto perf 1 Yes	s an 24b. ppsy ormed? 200 No	Were auto prior to con death? I Yes	psy findings available mpletion of cause of 2 No
Set N	Physician:	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	- T 45 10		Other	ath (Check only			
		ər this əral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie		4 ☐ Nursing F Injury at Work?		idence 6 Oth		y)
	tending	death. stor: Afte	atio	1NaNatural 5 ☐ Pending 2 ☐ Accident investigat	tion	ar) Injury	М	work? 1 ☐ Yes 2 ☐ No	-			
Division	al or Att	after de I Directo d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		At home, farm, soecify)	treet, factory, o	ffice	28f. Location City or To	(Street and Numb wn, State)	er or Rura	l Route Number,
	L To the Hospital	within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier ↑★★ Certifying (Check only one)	Physician: To the best of my saminer: On the basis of examiner stated.	knowledge, dea mination and/or i	th occurred at investigation, in	the time, date and place my opinion, death occu	e, and due to the urred at the time	cause(s) and ma , date and place,	inner as st and due to	tated. the cause(s)
	To th	within To th comp	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date signe		
				I Hen tra	rus Mb			027 415		Tehrung	4,	2006
		Ol		30. Name and address of person when the same and address of the same address of the same addre	no completed cause of death ((Item 23a) (Type	Print)	himter M	thical o	Center		
	والمراة	Sta	te	31. Date filed (Month, Day, Year)	ME. Hogistian 5 C	Signature	rate D					
		Registr		FEB 1 0 20	JUD June 1	100 /200	The state of the s					

Wright, MARY

1 - For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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U	Ü	O	O	-

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itame 23a or 28a-f show any Injury or other traumatic event, the Macical Examinat must be notified at once.

Willhelm, Constance

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the ettending physicien and d be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	riogistiai								og. 140.		
n	1. Decedent's Name (First, Middle, Las	t)						Date of Dea Month	th Day	∠ Year	3. Time of Death
al	Constance	Ann	Wi	11he1r				Februar			01:15 4 M
er	4a. Fecility Name (If not institution, give Bultimore Wasnington			4b. City, T Glen		Location of 1	Death	1		nne Aru	indel
	5. Social Security Number 6. Se		birthday)	If Under 1	Year	If Under 24	Hrs.	8. Date of Birth		O Bieth	place (Ctate or Foreign
	383-36-1680 10 Usual Residence of Decedent	□M 20XF 68	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day SEPT 21	119	37 Fargo	Michigan
	10a. State 10b. County	10c. City, T	own or Loc	cation						T-	10d. Inside City Limits
ctor	Michigan St Clai	r Ft Gi	ratio	t							1 ☐ Yes 2X No
Oire	10e. Street and Number			10f. Zip C	Code				_	izen of What Cou	ntry?
E E	3954 Keewahdi	n Road								USA	
nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decede Yes, specif	ent of His fy Cuban	panic Origin , Mexican, F	n? (Spec Puerto P	cify Yes or No- Rican, etc.)		 Race - American Black, White, 	
by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	☐Yes 2	No D	Specify:			ļ	Specify: W	hite
Be Completed	15. Decedent's Ed (Specify only highest grad	ucation 1 de completed)	6a. Deced	lent's Usual kind of work	Occupa done di	tion uring most o	f workin	g	16b. Ki	ind of Business/In	dustry
дшо	Elementary/Secondary (0-12) 5th	College (1-4or 5+)		se Ai					Н	ealth Ca	re
ပို	17. Father's Name (First, Middle, Last)		Nui	30 ///		18. Mother's	Name	(First, Middle,			
To B	James	Spooner				Ruth		P	nn	Chap	man
	19a. Informant's Name/Relationship (7	1								r Town, State, Zip	•
	Donald W. Willhel			145 SI sition (Name		cove (Pasader	_	MD 21122	
	20a. Method of Disposition 1 ☐ Burial 2 ☐XCremation 3 ☐	Removal from State	etery, crem	natory or oth	er place	natory		1 / ,		cation - City or To Hunon N	
	4 ☐ Donation 5 ☐ Other (Specify 21. Signature Fugeral Cervice Ligen:			. Name and			1	-		neral Ho	
	> Suld X	, X	1							D 21122	mie P.A.
	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition Diabets Mclifts										Onset and Death
	resulting in death)	Due to (or as a consequen	ce of):								
ē	Sequentially list conditions, if any leading to immediate	b. Due to for as a consaguer	ce of):								
Examiner	flany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
	resulting in death) Last	Due to (or as a consequen	ce of):								
an/Medical		d									
/Me	IF FEMALE:	23c. If yes, outcome of pregnancy	,		_				1	23d. Date of deliv	00/
	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3 🗌	Ectopic pre					- 111	Month	Day Year
Completed by Physic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown									
y F	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the un	nderlying cau	use givei	n in Part I.		23e. Did to	bacco u	ise contribute to t	he cause of death?
9								1 🗆 Y	es 21	ŽNo 3□Prot	bably 4 Unknown
ble								24a. Was a		24b. Were auto	opsy findings available impletion of cause of
200								perfor	med? 2 No	death? 1 ☐ Yes	2 No
Re	25. Was case referred to medical examiner?	Hospital:					f Death	(Check only or	10)		
0	1 Yes 25 No 27. Manner of Death	ipsunpatient 2 LER	Outpatient b. Time of			4 🗀 140151		e 5 Reside		6 ☐Other (Special	fy)
T On	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 20	c. Injury Work′ 1 □ Y	at ? es 2∐No		Bu. Describe in	ow injur	y occurred	
IICa	3 Suicide 6 Could not be determined	28e. Place of Injury - At home	, farm, stre	eet, factory,	office		2			d Number or Rura	al Route Number,
Cerr	4 Homicide	building, etc. (Specify)						City or Tow	n, State)	
Medical Certification:	29a. Certifier 1 Cartifying Phy (Check only one)	ysician: To the best of my knowle inar: On the basis of examination	dge, death and/or inv	occurred at restigation, i	t the time	e, date and p inion, death	place, a	nd due to the c d at the time, d	ause(s) ate and	and manner as s I place, and due to	stated. o the cause(s)
Mec	29b. Signature and title of certifier	and manner stated.		29c.	License	number	-		9d. Dat	te signed (Month,	Day, Year)
Hern Francis M						-415		February 5, 2006			
	30. Name and address of person who of		Ba) (Type, I			113			Un	73,2	

State

FRANCIS

31. Date filed (Month, Day Year) 2006

MD Ba Aimare Washinton Medical Center 32 Registrars Signature

State of Maryland / Departme

ent of Health and Menta	Hygiene	-	0	1	8	8	(
ate of Death	Reg. No.	100	6.0	1	0		0.0

			Registrer			Cen	ificate of L	Jeath		Reg.	No.			
	Physici	an	Decedent's Name (First, Middle, Last)							ite of Death onth	Day	Year.	3. Time o	
	/Medic		Robin Lee Welsh	nons					Fel	oruary	08, 2	.006	6:15	Ам
Sell Control	Examir	ıer	4a. Facility Name (If not institution, give s		1 4 .	100	4b. City, Town, or		Death		4c. County	_		
			602 S. Philadelphi			-	Aberdee	If Under 24	Hec. I a. B.		Harfo			
П	Funeral		5. Social Security Number 6. Sex 10	7. Age M 21≦F	e (In yrs. last bir 33	thday)_ Yrs.	If Under 1 Year Months Days			te of Birth onth, Day, Ye 1e 23 ,	ar)	Cour	olace (State	or Foreign
	Director		Usual Residence of Decedent		33				Jur	ie 23,	3, 1972 Maryland			
	dand		10a. State 10b. County		10c. City, Tow	n or Loc	ation					1	Od. Inside C	Dity Limits
	Man)	ğ	Maryland Harford		Aberde	een					1 A Yes 2 □ No			
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g.	Citizen of V	Vhat Cour	ntry?	
	h witi	0	119 Law Street				210	01			U	SA		
	deat	by Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin	? (Specify Y	es or No-			an Indian,	
9	after or its	5	1 □ Never Married 2 □ Married	1 ☐ Yes 2 ☐X1 If Yes, Give	1 0		Tes, specify Cuba ☐ Yes 2.5xtNo	Specify:	-uerto Hican,	etc.)		k, White,	etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f ehow he Mccloel Examiner must be notitled at	D D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				эрөспу.			Specify	. Wł	nite	
5	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	(Give k	nt's Usual Occupa ind of work done o	luring most of	f working	16b	. Kind of Bu	siness/Ind	dustry	
2	vithin ne.	m m	Elementary/Secondary (0-12)	College (1-4or 5			O NOT use retired,							
2	iled v tygie ther t		17. Father's Name (First, Middle, Last)	2	Med	dica	l Assist		Name /Fimt	Middle, Maid	Medic			
aŭ	ntal of o	Be		Welshons					_			•)		
Ž	hould d Me mark mark	ပ္	19a. Informant's Name/Relationship (Typ		10h	Mailine	Address (Street a		Lee	Wrigh	mber, City or Town, State, Zip Code)			
Maryland	d 2 s th an t7 ls													
	1 an Heel em 2		Mary Lee Welshons 20a. Method of Disposition	s / Mothe			Law Streetion (Name of	et, Ab	erdeen Date		Land .			
9	ages nt of t: If It		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemeter	y, crem	atory or other place	1				,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Modical Examiner must be notified at angle.		4 □Donation 5 □Other (Specify) 21. Signator of Funeral Service License		Harton		emorial (2-13-	06 Ab	erdee:	n, Ma	arylar	nd
Ba	perm Depa Impo any I		1 Au 1/0- 115	1		M	cComas Fr	uneral	_Home,	P.A.		_		
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do r	not ente	317 Coke:	SOUTY	rdiac or respi	Abinga ratory arrest.	on, M	aryla	Approxima	ate
	Discontinuo		shock, or heart failure. List only on Immediate Cause (Final	e cause on each lin	10.			1					Interval Be Onset and	
	Physician /Medical		disease or condition resulting in death)	Multy	a consequence		I Woun	de						
	Examiner		ſ	Due to (or as a	a consequence	ur).								
		e	Sequentially list conditions, if any, leading to annibulate cause. Enter Underlying		donsequence .	of).						-		
X	eath certificate be executed ettending physicien and I for use es the burial-transit	F	Cause (Disease or injury											
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ox 68760,	certificate be executed Iding physicien and Ise es the burial-transit	cai	d											
9	tifica ng ph es th	n/Medical	15.555											
	th ce endir		230. was decedent pregnant	3c. If yes, outcome of 1 Live birth		3 □6	ctopic pregnancy					of delive		
	dea he ett	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at 9☐ Unknown			Other (specify)				Mor	nth	Day	Year
Division of Vital Records, P.O.	Attending Physician: The law requires that the death r death. octor: After this certificate has been signed by the etter by the funeral director, page 2 should be detached for u	by Physicia	9 Unknown											
Ś	esth ignec		Part II. Other significant conditions con-	tributing to death bu	it not resulting in	the und	lerlying cause give	n in Part I.	23	Be. Did tobacc				/
ord	plnoi	Completed		-		_				1 🗆 Yes	2 ∐ No	3 Prob	ably 4	Unknown
e C	taw las b	ple							24	la. Was an autopsy	24b. V	Vere autor	psy findings	available
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ij	cian: entific actor,	Be	25. Was case referred to medical examiner?						Death (Chec	k only one)				
=	hysi this c	2	120 1-63 2 □ 140	ospital: 1 🗆 Inpatie				4 LI NUISII		Residence			at sc	ene
Ĕ	ing P	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) _ Ir	ime of	28c. Injury Work			escribe how in	jury occurre	ed		
<u>s</u>	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	tour 2/8/0,		0-1	1045	es 2 No		yeu se	- to			
\leq	or At	듣	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	./	•		28f. Lo	cation (Street by or Town, Sta	and Number	Sinth	Philey	nber.
	pitel ours a erel l		/ 29a. Certifier 1 ☐ Certifying Physi	laian Takabahan		ride			pour	levett.	Pourle	m, l	Imala.	1
()	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physical Check only one)	er: On the basis of and manner sta	examination and	dor inve	stigation, in my op	e, date and p inion, death o	place, and du- occurred at the	e to the cause ne time, date a	(s) and mai and place, a	nner as st ind due to	ated. the cause(:	s)
	ithin o the	Me	29b. Signature and title of certifier	and mainer sta			29c. License	number		29d. [Date signed	(Month, I	Dav. Year)	
)	⊢≯⊢ŏ		VT/ 11	Y			0	.C.M.E			ruary			
	1		30. Name and address of person who cor	mpleted of de	ath (Itam 23a) (Type P		• • • • • • •	•	TED.	Luary	0,	2000	
	O		TE DOUNE MILLIA	V	(200) (Penn St	reet,	Baltim	ore, M	arylaı	nd 21	201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	7 14								
	Registr	ar	FEB 1 0 2006	Marine	St. And	A Company								
					1									

Amend item#5, perffl, 332,2/13/06 II Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03890 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** February Christopher Wright 2039 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner handallstown Baltmore County Hospital oth West If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. 590ial Securif Olymber 250 - 862 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 10M 20F 250. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Randallstown MDBaltimone County Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21244 054 3807 Washington Avenue Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event SDGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WWG H Ernestine Wright ٩ Scan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 3807 Washing for Avenue Randalls town MD lowanda Wright WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cemetery Feb. 11, 2006 Lans downer MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility Funeral Schurce, P.A.
Hart P. Close Funeral Schurce, P.A.
5126 Belain Row, Baltimore mo 2,206 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 1 No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier marita neckens Broome M. O February 00050332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown MD 21133 5401 Marita Broome MD Old Court Boad 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

And

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	•	aryland / Dep		Health and M	ental Hygie		03891
			Decedent's Name (First, Middle, Last)		111	11115	0	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		MADELINE		W	ALKE	3/	2	7 2006	10:30a M
1	Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			Future Care N.H.	Homewoo			imore		NA_	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	ear) 9. Bit	thplace (State or Foreign ountry)
	Director		242-30-4351 Usual Residence of Decedent		80			8-4-25		N.C.
	yland		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	a-f sl	ctor	Md. NA		Bal	ltimore				Y Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	ath w	La	1800 E. #1st Str		8	21218			USA	
	er de items	Funeral	T. Maria Sara	2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show tre Madical Examinat must be natiliad at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 € Divorced	1 ☐ Yes 2 🐼 ! If Yes, Give Year or Dates:	40	1 ☐ Yes 2√ No	Specify:		Specify: B]	ack
Ö	2 hou atura		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occur	pation	16	b. Kind of Business	/Industry
215	within 72 ene. than "nai	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	life.	DO NOT use retire	during most of working)	ng		
2		Completed	10th grade			t Order			Resturant	
nd	d d al	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Sumame)	
yla		၉	Nathaniel		Bunch		Mary	Ann		Smith
Maryland 21215-0036	i2 s har 7 Is rrau		19a. Informant's Name/Relationship (Type Geraldine Moore	<i>s, Pnnt)</i> Sister			t and Number or Rura		•	
	1 an Heall em 2		20a. Method of Disposition	pracer	20b. Place of Disp	osition (Name of	t. Street,		re, Ma. c. Location - City o	
Baltimore,	of of Til		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	King Me	matory or other pla	2-11	_06 P	andallsto	- Ma
₩		H	21. Signature of Funeral Service License	θ .		2. Name and Addre			more, Md.	
Ba	permit. Departr Importr any inj		I Lement M	Hierry	ent	March F.	H. East		North Av	
760, 4	And the puriat-transit white buriat-transit with the buriat-transit with the buriat-transit with the buriat-transit with the puriat-transit with the buriat-transit with the b	Ilcal Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Souther the first condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	ke	cerebro			Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	sy		23d. Date of de Month	olivery Day Year
Records, P	uires that n signed to lid be deta	by	Part II. Other significant conditions con		ut not resulting in the u	underlying cause gr	ven in Part I.			o the cause of death?
00	aw require s been sign	Completed	direstes					24a. Was an	24b. Were a	utopsy findings available
Re	The lav	mo						autopsy performe 1 Yes 2	d? death?	completion of cause of s 2 \subsection No
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Death			
of V	ys diib	10 E	1 Yes 2 140	ospital: 1 🗌 Inpatie		nt 3 DOA	White of the William Co. Co. Co.	me 5 Residenc	ce 6 □Other (Spe	ecify)
п		:uo	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time of Injury	Wo		28d. Describe how	injury occurred	
Division	uttendii death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	00 84 (1-1			Yes 2 □No	Opt I continu /Ctro	at and Number or C	tura l Davida Alverta a
Σ	or Attendate death Diractor:	artif	4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		City or Town,		lural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune				of my knowledge, dea					
	he Hc in 24 l ha Fu pletelly	edical	(Check only 2 Medical Examir one)	er: On the basis o and manner sta	f examination and/or in ated.	ivestigation, in my	opinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	To the I within 2 To tha I complet	M	29b. Signature and title of certifier	0 01/	\	_	se number	290	Date signed (Mon	th, Day, Year)
	į		NAMINA	Cylvie	/	DO	027860) H	DUAY	1", 2006
<u> </u>	H		30. Name and address of person who co	KENKI	VEY MD	Print) 2700 A	J. Chris	St BLA	H MU Z	21218
	Sta Regist		31. Date filed (Month, Day, Year) FR 1 0 2004		ar's Signature	ile)				

		1 - For State Registrar	State of Mary	land		artment rtificate			ind M		giene Reg. Nö.	006	03892
Physicia /Medic		Decedent's Name (First, Middle, Last)	ADA L		WALL	S				2. Date of Dea Month EBRUAR	Day	Year 7, 20	3. Time of Death
Examin		4a. Facility Name (If not institution, give Saint Joseph		Cent	er				OWS	n	4c. (ltimore
Funeral Director				978. /as	Yrs.	If Under 1 Months	Year Days	Il Under 2 Hours	Min.	8. Date of Birt (Month, Day 12-16-	h y, Yea <i>r)</i> -1917	9. Bi	rthplace (State or Foreign country) NNSYLVANIA
Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD. BALTIN		c. City,	Town or Lo		LTI	MORE					10d. Inside City Limits 1 ☐ Yes 2(C)No
with the 3a or 28a-	i Director	10e. Street and Number	ATE DRIVE			10f. Zip 0	Code	212			10g. Citiz	zen of What C	country?
ING 21215-0036 be filed within 72 hours after death with the Maryland ital hygiene. In other than "natural", or Iteme 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:	r in U.S.		Was Decede f Yes, specif	nt of His y Cubar		in? (Spec Puerto F	cify Yes or No- Rican, etc.)			erican Indian,
Maryland 21215-0036 Id should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)		(Give life. L	tent's Usual kind of work DO NOT use	done d retired,	ution Juring most AID	of workin	g		LTH C	ARE
rland 2 uld be filed Aental Hygia rked other	To Be C	17. Father's Name (First, Middle, Last)	GEORGE WI	LSO	N			18. Mothe	r's Name	(First, Middle,		Sumame)	
		19a. Informant's Name/Relationship (7) BETTY JANE COOK								Route Numbe			Zip Code) LAND,21212
OTG est of Her		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cen	netery, cren	sition (Name natory or oth OF FAI	er place	9) 0		-2006		Cation - City o	r Town, State MARYLAND
Baltimo		21. Signature of Funeral Service Licens	(R.G	i.RU		. Name and UCK TO				HOME, I	NC.	1050 TOWS0	YORK ROAD N,MD.21204
Physician		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the ne cause on each line.	death.	Do not ente	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co			INFE	OTI(DN					
and transit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
OST 68 / 60,	cai		d.	nseque	nce or):								
.O. BOX 68 the death certific by the ettending pl ached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal de	eath 3	Ectopic pred Other (spec				23d. Da Mo			blivery Day Year
	by	Part II. Other significant conditions co	ntributing to death but no	ot resulti	ing in the ur	nderlying cau	ıse give	n in Part I.		23e. Did to	1	1	to the cause of death?
The lay	Completed			-						24a. Was autop perfor	SV	24b. Were a prior to death?	
w =	To Be (25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 VInpatient	2 🗆 EF	₹/Outpatien	t 3 DOA	Othe	r		(Check only on	ne)	☐Other (Sp.	ecify)
C g age	Certification;	27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 21	8b. Time of Injury	M 28	c. Injury Work 1 🗆 Y	at ? ∕es 2 □ N		8d. Describe h	iow injury	occurred	
DIVISIO DIVISION TO the Hospital or Attendividin 24 hours effer death. To the Funeral Director: A completely filled in by the formal of the formal or the	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	ipecify)						City or Tow	m, State)		Rural Route Number,
the Hosp in 24 hou the Fune apletely fil	ledical	(Check only 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	y knowle imination	edge, death n and/or inv	vestigation, i	n my op	pinion, deat	d place, a h occurre	d at the time,	date and	place, and du	e to the cause(s)
To To Tro	∑	29b. Signature and title of certifier	w		>		License	number 254			29d. Date	signed (Mor	ith, Day, Year)
3		30. Name and address of person who co				Print)			1 10175	10 21 AV	mg ,m ,	em grape J.	
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 0 200	32. Hegistrar's	Signatur	re 🦽	ALVE -		2W CO 1311	पड़ स्मिन	RYLANI	J El	h ()	

		. 101	artment of Health and Me <i>rtificate of Death</i>	ntal Hygier	(000 0000
		1. Decedent's Name (First, Middle, Last)	2	Date of Death	3. Time of Death
Physicia /Medic		Shirley B. Wilhelm	Fe		8, 2006 6:00a M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		4765 Winterset Way	Owings Mills		Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	Date of Birth (Month, Day, Yea	1000
Director		219-34-6857 G7 Yrs. Usual Residence of Decedent		June 27,	1938 MD
/land		10a. State 10b. County 10c. City, Town or Let	ocation		10d. Inside City Limits
Man, Ifed	ţō	MD Baltimore Owings	s Mills		1 ☐ Yes 2X No
r 288	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
th wit	a D	4765 Winterset Way	21117		USA
be filed within 72 hours after death with the Marylan lat! Hygiene. I hours after death with the Marylan do other than "natural; or lterns 23a or 28a-f show avent, the Medical Examiner must be nutified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - American Indian, Black, White, etc.
or It		1 Never Married 2 X Married 1 Yes 2 No	1 ☐ Yes 2 🖾 No Specify:	Jan, 010.7	Specify:
nours ural',	d by	3 Wildowed 4 Divorced Year or Dates:			White
"nat	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b.	. Kind of Business/Industry
within she she she she she she she she she she	d mo	Elementary/Secondary (0-12) College (1-4or 5+)	ısewife		Own Home
filed Hygi ther		17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maid	
d be ental ked o	To Be	George E. Caltrider			·
should be filed within 72 hours after death with the Maryland nod Mental Hygiene. In the Maryland to Mental Hygiene and the than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show umatic avent, I're Medical Exertirer must be natified at	F		Edna F		v or Town, State, Zip Code)
nd 2 lith a 27 is r trau		Paul M. Wilhelm, Sr. Husband 4765	Winterset Way, Owin	ngs Mills	s. MD 21117
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, tra Magnee.		20a. Method of Disposition 20b. Place of Dispo		-	Location - City or Town, State
Pages nent of int: If it		1 XBunal 2 Cremation 3 Hemoval from State	Mem. Gardens 2/11	/06 Ed	inksburg, MD
permit. DepartmImporta		Lvergreen	2. Name and Address of Facility		eisterstown Road
permi Depa Impo any ii		Time I time	Lline Funeral Home		
TOTAL BANK		23a. Fant 1. Enter the disease, or complications that caused the death. Do not en slock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Imme late Cause (Final dise se or condition	CRHCER		Onset and Death
/Medical	-	Due to (or as a consequent of):			
Examiner		Sequentially list conditions, b.			
D #	Iner	if any, leading to immediate Due to (or as a consequence or):			
and I-tran	Examiner	Cause (Disease or hijury that initiated events resulting in death) Last			
cate be executed physician and the burial-transit	alE	500 10 (01 03 0 03 100 03).			
cate cate	dical	d			
certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
death atter	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year
the cay the achec	hysi	9 Unknown			
s that	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
quire an sig uld b		None Known		1 🗆 Yes	2 No 3 Probably 4 Unknown
aw re s bee 2 sho	Completed			24a. Was an	24b. Were autopsy findings available
The I	шо			autopsy performed 1 Yes 2	
rtifica tor. p	0	25. Was case referred to medical	26. Place of Death (C		10 103 2010
lysici lis cel direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	****	6 ☐ Other (Specify)
ng Ph		27. Manner of Death 1 Matural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at 28c Work?	d. Describe how in	ijury occurred
andii eath. or: A the fu	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
or Att ter de iract	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, sti building, etc. (Specify)	reet, factory, office 28f	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
oital o	O				
Hosp 4 hou Funa tely fi	edical	29a. Certifier (Check only (C	h occurred at the time, date and place, and vestigation, in my opinion, death occurred	I due to the cause at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
To the Hospital or Attanding Physician: The law requires that the death certifurwithin 24 hours after death. I the Funaral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Med	one) and manner stated. 29b. Signature and title of certifier a	29c. License number	29d [Date signed (Month, Day, Year)
F 3 F 8		11- 1 And mir.	D15552		2/8/06
1		House 12 - 17	Print)		
)		Howard Jaiontz, M.P. 23 Cress	runds Dr Ste#	240 01	NIAS M. 118 W. J. 2111
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-	nings M.118 med. 2111
Registra		FEB 1 0 2006	Coulis		

ORIGINAL

			State of Maryland / De	partment of Health and Nertificate of Death	•	2e 006	0389L
,	1 1		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		MATTHEW FREDERICK WELSH		FEB. 3, 2	2006	11:00P [™]
	Examin	1	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	1
		4	279 S. ROBINSON STREET	BALTIMORE		N/A	
Ð.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 210-38-6637 1 PM 2 F 63 Yrs.	(y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye DEC. 19,	9. Birth	splace (State or Foreign untry)
	Director		219~38~6637 XM ZUF 63 Yrs. Usual Residence of Decedent		DEC. 19,	1942	MD.
	land ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Man I sh	tor	MD. N/A BALT	IMORE			1 ☐ Yes 2 ☐ No
	r 282	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?
	th wit	aiD	279 S. ROBINSON STREET	21224	UN	ITED STATI	ES
	ams ams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No Specify:		Secritiv	
Ö	tural'	q pe	3 ☐ Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	166	Wind of Business/I	HITE
7	in 72 nair	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of wor DO NOT use retired)	king	. Kind of business/i	ndustry
77	iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) O M	MAILER	5	SUNPAPER	
פַ	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or tame 23a or 28a-f show avent, the Medical Exam, per must be medilied at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	den Sumame)	
lar	uld bu Menta rkad ric si	To E	MATTHEW J. WELSH	ELLA MA	Y KANELY		
Maryland 21215-0036	and l			tiling Address (Street and Number or Ru			
	and ealth m 27			2 BONNIE VIEW LANE			
Ore	ges 1 t of H if Ite or otl		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of rematory or other place)		. Location - City or T	
ij	t. Partmen			CREMATORY 2/7/ 22. Name and Address of Facility CR	2006 BA	ALTIMORE,	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Beginner of Health and Mental Hygiene Happortment: or Itams 23a or 28a-f show surpportant: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show inpropriating or other traumatic avant, Ita Medical Exam. per must be notified at ODCs.		21. Signature of Funeral Service Licensee	6224 EASTERN AVE.,			
			23a. Part Lenter the disease, or complications trial caused the death. Do not a shock for heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
redail	Pnysician :		Immediate Cause (Final disease or condition	MYOCARDIAL	INFARCT	ION	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	~ 110	100.00		
		<u></u>	Sequentially list conditions, if any, leading to immediate b. TYPE 2 Due to (or as a consequence of):	DIABETES			
	tec nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ENSINA			
<u>,</u>	be executed sician and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):	C/4 3/0/4			
760,		cai	CORONAR	Y ARTERY DISE	ASE		
68	tificate ig physi as the t	edi					
ŏ	leath certificat attending phy I for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	· ·
P.O. Box	e dea he att	Physician/M		Other (specify)		Month	Day Year
<u>~</u>	w requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the	a underhing cause gwee in Part I	23a Did tobacc	co use contribute to	the cause of death?
Š,	signe signe	by	Tate in Street Significant Solidarists Commoding to death but not resulting in the	underlying cause given in Parti.			bably 4 Unknown
Ö	y requ	etec			24a. Was an		
Records,	2 2 3	Completed			autopsy performed	Prior to a death?	opsy findings available ompletion of cause of
Vital	iclan: Th certificate rector, pag	ပိ	25. Was case referred to medical	26 Place of Dea	th (Check only one)	No 1 ☐ Yes	2 No
>	ysicla s cert direct	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	04	ome 5 Residence	6 □Other (Spec	ıfv)
0	ding Phys h. After this funeral di	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how in		
<u></u>	endir eath. or: Af	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	aftar death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rui tate)	ral Route Number,
Ω	urs all		200 Contilion Physician Tube				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Euneral Director: Attenthis certificate ha completely filled in by the funeral director, page	edical	29a. Certifier Check only (Check only one) Check only one) Check only one) Check only one)	investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	o thi	Me	29b. Signature and the of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
	> - 0		I Susan L. Burgert M	D D 44910	0	2/06/	2006
	\wedge		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			
	, /		SUSAN L. BURGERTIM	e, Print) OMPREHENSIVE CA	RE PRACTIC	CE SZWE	ASTERN AVE
	Sta Registr	1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.34			
DH	MH 17 Rev 1/20	ş ji	1 TO T O 2000	gener			

ORIGINAL

			1 - For State Registrar	State of M	arylan		artmen rtificate			and M		Reg. No.	06 (3895
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	Day	Year	3. Time of Death
1	/Medic Examir		VIVIAN E. ANDER 4a. Facility Name (If not institution, give s)		4b. City,	Town, or	Location of	of Death	FEB.	10 4c. Cd	2006 ounty of Death	6:40 A. ^M
	- LXuinii	e i	ROCK GLEN NURSING	HOME			ВА	LTIN	ORE					
***	Funeral Director		5. Social Security Number 6. Sex 218-05-1599	7. A	ge (In yrs. I 86	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir Month Da 09/16	"/ 1919	9. Birthr Cour	place (State or Foreign intry) MD
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation						1	10d. tnside City Limits
	a-fsh	ctor	MD			BALTIN	IORE							1√ Yes 2 No
	or 28	Dire	10e. Street and Number		·		10f. Zip					10g. Citizer	n of What Cou	ntry?
	e 23a	erai	56 S. CULVER STRE	ET 12. Was Decedent	Ever in III	S 12	Man Doord	212		~in? (Ca	actu Van ar Na	14	USA Race - Americ	oon to disc
36	within 72 hours after death with the Maryland ane. than 'natural', or iteme 23s or 28s-1 show na Medical Exempleat found by recitified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		f Yes, spec		Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, White,	etc.
21215-0036	2 hou	ted	15. Decedent's Edu	cation		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind	of Business/In	dustry
21	ithin 7 nen "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wor DO NOT us			OF WORK	ng			
22	iled w Hygier ther th	S	17. Father's Name (First, Middle, Last)				DOMI	ESTI		r's Name	(First, Middle,		HOME	
Maryland	d be f	To Be	SIMON P. CLARK							AGGI		WILS		
ary	shoul ind Me mark	ř	19a. Informant's Name/Relationship (Type			19b. Mailir	ng Address	(Street a			al Route Numbe			Code)
Ž	and 2 saith a n 27 is		VICTOR R. TALLEY	Y/NEPHEW		56	S. CI	JLVE	R STR	EET,	BALTO.	, MD	21229	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Exacting from the profiles at angle.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	C. CE	lace of Dispo emetery, crea			4.	1	0 6		MORE, I	
Balt	permit. Departr imports any inj		21. Signature of Funeral Service License	Mol	m	22	2. Name and			JA	MES A. BALTO.			NSF.H., INC
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	2		30. Name and address of person who co	afte (a)	death (Item	23a) (Туре,	Print)	۷7	Anna	poli	is Rd.	Balt	a, MD	21727
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Amend item#5, periff, C857, 2/13/(6,11)
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death v 10, **Physician** Dorothy February 2006 6:15PM Ahmanson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bond's Forest Assisted Living Carroll Finksburg If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) May 12, 1928 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 M 2 T 77 204 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2X No MD Director Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6673 Mid Summer Night Court 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give² Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 🌠 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker/Artist Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Mensh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 Davador Sara 19a. Informant's Name/Relationship (Type, Print) Mr. Theodore Ahmanson (Son) 6673 Mid Summer Night Court Eldersburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 2/13/06 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNRAL HOME & CHAPEL, (Box 195) Duar Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence & Other (Specify) \$105 PICE 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician: To the Hospital within 24 hours a To the Funeral I the Hospital

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Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

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31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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170		30. Name and address of person	n who count	pleted cau	ise of death	(Item 23a) (Ty	pe. Print)	1) a	25.8	1 /	,		412/	40	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month 1509 Logan Nathan 2006 anuary 4a. Facility Name (If not institution, giye/street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA 104 John 1. FINOU.C If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 19, 2006 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 10**X**M 2□F Months Days Hours Min Yrs. NA Baltimore MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? REGister Ave 21212 USA 636 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Christian Logan Coles Jennifer Elizabeth Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Coles / Mother KEGWE Are BAHIMOR MO 21212 636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Jan. 28, Sag Harbor, NY Oakland Cemetery 2006 21. Signature of Auneral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Paltimore MD 21230 23a. Part1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Cardiac Dystunction days disease or condition resulting in death) Due to (or as a consequence of)

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d 2 should be filed within the and Mental Hygiene.

item 27 l

10 = 0

permit. Page Department of Important: If eny injury or once.

Funeral Director

þ

Completed

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kulmonari

Neuro log 1c Suppression

9□ Unknown

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

6 ☐ Could not be

Ygar)3

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 🗌 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) anuary 24, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital 600 N. Wolfest. Baitimore, MD 21287 Carolyn Boylan, MD 31. Date filed (Month

State Registrar

32. Registrar's Signature

	-	For State Registrar	State of M	larylar	_	artmen tificate			nd Mei		giene	16	03900
Physiciar /Medica	-	1. Decedent's Name (First, Middle, Las Maurice Joseph Cod	•						2. F	Date of Dea Month ebruar	bay, 20	006 ^{Year}	3. Time of Death 03:20 at
Examine	r	4a. Facility Name (If not institution, give Stella Maris Hospi	ce			Balt	imor					nty of Death	
Funeral Director			X 7. A	ge (In yrs. 82	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min. J	Date of Birth (Month, Day an 2,	1924	9. Birth Cou Mary	place (State or Foreigntry) Land
-f show		Usual Residence of Decedent 10a. State 10b. County MD Baltimor	:e		y, Town or Lo utus	cation							10d. Inside City Limi
3a or 28a	Funeral Director	10e. Street and Number 5527 Ashbourne Rd.				10f. Zip					10g. Citizen o	f What Cou	intry?
S. J. H.	_	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Armed Forces 15 Types 2 1 If Yes, Give 1 - Year or Dates	?		Was Deced f Yes, spec	rfy Cubai	spanic Origin, Mexican, Specify:	in? (Specifi Puerto Ric	y Yes or No- an, etc.)	В	ace - Ameri lack, White cify: Whi	etc.
itied within 72 ho I Hygiene. other then "natur ent, tre Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ccation de completed) College (1-4or	5+)	16a. Deced (Give life. I	kind of wor OO NOT us	k doné d e retired,	ition uring most	of working		16b. Kind of		·
permit. Pages 1 and 2 should be tied within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny Injury or other treumatic event, Ita Ma page.	a l	17. Father's Name <i>(First, Middle, Last)</i> William Ridgely Wi	lson Cool	k, Sr	•						Maiden Sumi		
Health and 2 sho	-	19a. Informant's Name/Relationship (T Jaquelen K. Arrage			PO Bo	ox 35	Tas	nd Number ley V	A 234	41	r, City or Tow	n, State, Zij	o Code)
2 5 2 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify			Place of Disponentery, cremetery,	natory or of	her place		Date 10–20		20c. Location Baltim		
Departr Departr Importu eny Inji		21. Signature of Funeral Service Local	sough	d	1.	328 St	ılphi	ur Spi	ring 1	, Inc. Rd. Ar	butus	MD 21	227
Physician /Medical Examiner		23a. Part1. Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. LUNG Due to (or as	CANCE	ER	er the mode	of dying	, such as c	ardiac or re	espiratory arr	rest,		Approximate Interval Between Onset and Death
cate be executed. physicien and the burial-transit	LYB	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as										
ine raw requires that the death bettings his has been signed by the ettending phoage 2 should be detached for use as the completed by Dhysel i jan/Maddi	iysicialiymed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	Ectopic pre						Date of deliv	ery Day Year
been signed the should be detailed to the should be detailed to the should be detailed by Digital b	2	Part II. Other significant conditions co	ntributing to death t	out not res	ulting in the ur	nderlying ca	iuse give	n in Part I.					the cause of death?
	adillo.									24a. Was a autops perfor		prior to co death?	opsy findings availatempletion of cause of
certificate	ט	25. Was case referred to medical examiner?					1 -		of Death (C	heck only or	76)		
sign P	2	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpati		ER/Outpatien			4 14013					fy) HOSPICE
Affer	Callon	27. Manner of Death 1	28a. Date of Inju (Month, Da		28b. Time of Injury	М		at ? ′es 2 □ N	0		ow injury occi		al Route Number,
within 24 hours after diverse to the Funeral Director: To the Funeral Director: completely filled in by the		4 Homicide determined 29a. Certifier 11 Certifying Phy	building, e	tc. (Specif	v) 			- data and		City or Tow	n, State)		
within 24 hours et of the Funerel I completely filled		(Check only 2 Medical Examone)	sician: To the best ner: On the basis of and manner st	of examina	tion and/or inv	estigation,	in my op	inion, death	occurred	at the time, d	late and place	a, and due t	o the cause(s)
Z IN LO		29b. Signature and little of certifier	,				License	number - 372	2-5		29d. Date sign	7/00	,
State		30. Name and address of person who c DR. TARIQ MAHMOOI 31. Date filed (Month, Day, Year)		ULANE	Y VALL		. Т	'IMONI	UM,MD	21093	3		

DHMH 17 Rev 1/2001

FEBRUARY 7, 2006 3:20 a.m.

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			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>		of Health			iene		03901
			1. Decedent's Name (First, Middle, Las		0 .				2. Date of Deat	h		3. Time of Death
	Physic /Medi		Gernaro	1 B.	Cor	ren			Februar	Day	Year LOO 6	813 GM
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or Location	on of Death		4c. County		
			Northwest Ho	spilal	Center	Rav	dalls	hour	7	Bal	tim	ore
	Funeral	8	5. Social Security Number 6. S		e (In yrs. last birthday	If Under 1	Year If Unc	der 24 Hrs.	8. Date of Birth		9. Birthpl	ace (State or Foreign
35	Director		215-12-7270	XM 2□F	86 Yrs.	Months	Days Hour	rs Min.	0CT.6,1	.919	Coun	^(ry) MD
	pr ,		Usual Residence of Decedent									
	aryla ehov	Ļ	10a. State 10b. County		10c. City, Town or L						10	Od. Inside City Limits
	Ba-f	cto		IMORE	BAL	TIMORE						1 Yes 2 No
	or 2	Olre	10e. Street and Number			10f. Zip C			1	0g. Citizen of V	Vhat Coun	
	ath w	Ta .	7 SLADE AVENUE #					21208				USA
	tems	Tue.	11. Marital Status	12. Was Decedent Armed Forces?		Was Decede If Yes, specif	nt of Hispanic y Cuban, Mexi	Origin? (Specican, Puerto F	cify Yes or No- Rican, etc.)		e - America	
36	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow Le Medical Exertine trast by ricifiled at	by Funeral Director	1 Never Married 2 Married	1 X Yes 2 If Yes, Give	No WWII	J□Yes 2	√ No Spece	city:		Specify		
21215-0036	hour tural	D D	3 Widowed 4 Divorced	Year or Datels	KCH MAKIN		-					WHITE
7	"nai	Completed	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usual kind of work DO NOT use	done durina m	nost of workin	g	16b. Kind of Bu	isiness/Ind	lustry
12	withii ene.	Ę	Elementary/Secondary (0-12)	College (1-4or 5	C.P		, emec)			ACCOUN ⁻	LING	
	filed with Hygiene othar the		17. Father's Name (First, Middle, Last)	<u> </u>	0.1	• / •	18 Mo	other's Name	(First, Middle, N			
aŭ	ould be Mental arked o	9 Be	ABRAHAM		СОН	FN		HELEN	() mat, madro, n	Maiodii Ourriani		INSKY
Maryland	should nd Men marke umatic	P	19a. Informant's Name/Relationship	Type Print)					Route Number,	City or Tour		
Z	d 2 sho th and th mu traum			WIFE					BALTIMO	-		
Ġ,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If itam 27 is marked othar then "natural", or items 23s or 28s-f ehow or other traumatic event, If a Maclical Exercities from the inclined as		20a. Method of Disposition	NIIL	20b. Place of Disp	osition (Name	of			20c. Location -		
ē	Pages nent of I int: If its iry or o		1 X Buriat 2 ☐ Cremation 3 ☐		cemetery, cre	-		1				
Baltimore,	permit. Pag Department Important: any injury c		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		ARLINGTO							E, MD
Ba	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		21. Signature of Purishar Service Licent	1 AH			Address of Fa	301	LEVINS		-	
			23a. Part1. Enter the disease, or comp	cooper					ROAD - P		LL,	MD 21208
Ĵ.			snock, or neart failure. List only	one cause on each in	ne.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a HV+V	eroscle	rutic	. Lav	rdiov	ascula	v Disto	Se	
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	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) 43	a consequence or).							
	and and Il-tran	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						_	
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87	phys the	dlcal		. d. =								
×	The law requires that the death certific ste has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							
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Ö	at the de by the a tached	yslo	1 Yes 2 No 9 Unknown	9☐ Unknown	time or death 5t	_ Other (spec	шу)					
P.0	that t		Part II. Other significant conditions co	ontributing to death b	ut not resulting in the t	nderlying cau	se given in Pa	urt I	23e. Did tob	acco use contr	ibute to the	e cause of death?
of Vital Records,	sign d be	d by		•	· · · · · · · · · · · · · · · · · · ·		g.r			s 2 🗆 No		
Ö	w requir been si should	ete										
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al									perform 1 Yes 2	No 1	eath?	2 🗆 No
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	ding P h. After funer	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o		: Injury at Work?		8d. Describe ho	w injury occurre	ed	
Division	ten feat for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2					
<u>≥</u>	I or Attendated after deatl	E	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, o	office	2	8f. Location (Str City or Town,		or Or Rural	Route Number,
	To the Hospital or At within 24 hours after C To the Funeral Directompletely filled in by											
	Hospital 24 hours a Funeral I	Medical	Check only 2 Medical Exam	iffier: On the pasis of	of my knowledge, deat examination and/or in	h occurred at vestigation, ir	the time, date my opinion, d	and place, ar death occurre	nd due to the ca d at the time, da	use(s) and mai te and place, a	nner as sta	ited. the cause(s)
	To the within 2. To the I complet	Меа	29b. Signature and title of certifier	and manner sta	ited.		icense numbe		7			
	₹ <u>₹</u> 5 8		200. Signature and this of Certifier	300		29C. l	_		29	d. Date signed	(Month, D	vay, rear)
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2.	41		30. Name and address of person who o				, ,	0	A			. 2 . 2 7
0	ura .		31. Date filed (Month, Day, Year)			sid co	urtk	a Ka	indall	SPWN	, M	0 21133
	Sta Registr	_		2006	ar's Signature	person						

CHARLES DAVIS

			For State Registrar	Please T	ype or Pring State of Ma		d / Depa	rtme		lealth a	and M	•	/gieņe	ำกก	le.	13903	
		-		e (First, Middle, Last)			Cei	liiiCa	ile or i	Jealii		2. Date of D	Reg. No			3. Time of Death	_
	Physici	an	1. Decedent's Name	Charles			Davi	İs				Month 2	10 Day	20	Year 06	1:40a	
	/Medic		4a Fecility Name //	f not institution, give :	street and number)		Dav.		y, Town, or	Location of	of Death			County o		1.400	
	Examin	er		la Maris I				40.0	Timo		J. 2004		'		timo	re	
	Funeral		5. Social Security N			e (In yrs.	last birthday)		ler 1 Year	If Under		8. Date of B	irth			ace (State or Forei	ign
	Director		241-40-0	604 ¹ X]M 2□F	75	Yrs.	Month	s Days	Hours	Min.		ay, <i>Year)</i> ·20–3(Coun	N.C.	
	p .		Usual Residence of									77			10d. fnside City Limits		
	arylar how	_	10a. State	10b. County		10c. Cit	y, Town or Loc								1	od. miside City Limi 1 X Yes 2 ☐ N	
	Ba-f	Director	Md.	NA			Baltir	_									
	with the	ä	10e. Street and Nur	_{mber} dnor Avenu	0			10f. i	Zip Code 21212)			10g. Cit	izen of Wi	nat Coun	try?	
	234	Funeral				Ever in 11	C 12 V	Van Da			ain? /Cn	noity Van as N		14. Race	- Amoric	an Indian	_
_	ter di	Š	11. Marital Status	ied 2 Married	Armed Forces? ff Yes, specify Cuban, Mexican, Puerto Rican, etc.)							, White,					
215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "natural", or Iteme 23a or 28a-f ehow event, Ite Medical Examinat must be notified at	þ	3 Widowed		1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:				2 No	Specify:				Specify:	В.	lack	
Ž	2 hou	Completed	/0-	15. Decedent's Edu			16a. Deced	ent's U	sual Occupa	ation	A + 6	·	16b. K	ind of Bus	iness/Ind	lustry	
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ā	12 sh and n ris m	- 9		ame/Relationship (Ty	, , ,			-				al Route Num			tate, Zip 2121:		
	es 1 and 2 should b of Health and Ment of Item 27 is marked ir other traumatic e		Linda L		Wife	20b. F	OZO Place of Dispos	THE PERSON		Avenue		altimor	,	ocation - C			-
ıtımore,	Pages nent of I ont: if Ito		1√∑ Burial 2	☐Cremation 3 ☐P	lemoval from State		emetery, crem	atory o	r other plac								
				5 Other (Specify)	90	Ki	ng Mem		and Addres		2-15-		_	ndal. ore,		vn, Md. 21202	_
g	permit. Departimporti) JA	0 - 8 -	Wome	\sim			h F.F		,	1101	E.	North	a Ave	3.	
			23a. Part 1. Enter t	he disease, or compfi int faifure. List only or	ications that caused	the deat	h. Do not ente	r the m	ode of dyin	g, such as	cardiac	or respiratory	arrest,		T	Approximate Interval Between	
,n,	Physician /Medical Examiner portion and private transit private transit physician ph	al Examiner	Immediate Cause disease or condition resulting in death) Sequentially list confidency, leading to incause. Enter Unde Cause (Disease or that initiated events resulting in death)	inditions, inditions, inmediate shying injury s	Due to (or as	a conseq a conseq	uence of):									Onset and Death	
.O. BOX 68/6	res that the death certificate be executed signed by the attending physicien and be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	t pregnant 2 months?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	il death 3□		pregnancy (specify)	,				23d. Date Mont		ry Day Year	
ŝ	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other signif	ficant conditions cor	ntributing to death b	ut not res	ulting in the un	derlyin	g cause give	en in Part I						e cause of death?	
cord	w require been sig should t	ted										1	Yes 2			ably 4X Unknow	
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X	Physicien: r this certific ral director,	Be c	25. Was case referexaminer?	1	fospital:		IED/C		Othe	05		h (Check only		. Tr.	16	. HACTT	
ō	ding Phys h. After this funeral dir	1.70	1 ☐ Yes 2 XX		28a. Date of Inju		ER/Outpatien	3□	DOA	4 🗆 140		me 5 Res 28d. Describe				HOSPIC	E
0	ding th. : Afte	tlor	1 XNaturaf 2 ☐ Accident	5 Pending investigation	(Month, Day	ý Year)	Injury	М	28c. fnjun Worl	k? Yes 2□							
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ury - At h	ome, farm, stre (y)	et, fact	ory, office				(Street an own, State		r or Rura	l Route Number,	
	29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occ						ath occurred at the time, date and place, and due to the cau investigation, in my opinion, death occurred at the time, dat			a cause(s) and manner as stated. b, date and place, and due to the cause(s)							
	within 24 in To the Fu	×	29b. Signature and	title of certifier				7	29c. Licenso	e number			29d. Da	te signed	(Month,	Day, Year)	
	~			11.					DY	372	5		5	2/10	106		
	in		30. Name and addr	ress of person who co	ompleted cause of d	eath (Iter	n 23a) (Type, I	Print)			-						
	0									TIMON	IUM,	MD 210	093				
State Registrar FFR 1 3 7006						ars Signa ر مسھ	ature	esti									

FEB 1 3 2008

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4c. County of Death Lebruary /Medical 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
August 27, 1924 Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days 217-12-0322 81 Director Baltimore, MD Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at MD Baltimore 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1445 Boyle Street 21230 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "naturel", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Dept. 12 Retired Police Officer traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles E. Eyler Sr. Marie Scalio 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 l Betty Lou Eyler 1445 Boyle Street Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State - - b 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 10, permit. Page Department of Important: If any injury or once. Baltimore MD Bayview Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave . Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial

Due to (or as a consequence of): hour /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Medical Certification; To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably ancivima 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA (his within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the 29b. Signature and title of certifier 29c. License number 10 State Registrar

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1 1	-	Sal	U	6
101	1	458	10	

Baltimore, Maryland 21215-0036		1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be notified at engine.	Funeral Director	/Medi Exami
		ca ne

Phys /Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Certificate of Death	Reg. No.
ician	Decedent's Name (First, Middle, Last) BESSIE ELIZABE	Mo	te of Death onth Day Year 3. Time of Death
dical niner	4a. Facility Name (If not institution, give street and number) 58 MADISON ST.	TH ECKARD FE 4b. City, Town, or Location of Death WESTMINSTER	B. 8, 2006 2:45 P ^M 4c. County of Death CARROLL
al or	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	inthday) If Under 1 Year If Under 24 Hrs. 8 Dat Months Days Hours Min. (Mc	te of Birth onth, Day, Year) / 18 / 1919 MARYLAND
ctor		wn or Location MINSTER	10d. Inside City Limits 1 \overline{M}Yes 2 □ No
al Director	10e. Street and Number 58 MADISON ST.	10f. Zip Code 21157	10g. Citizen of What Country? USA
To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 No Specify:	as or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE	16b. Kind of Business/Industry HOME MAKER
To Be Co	17. Father's Name (First, Middle, Last) CHARLES V. WINTE	18. Mother's Name (First,	Middle, Maiden Sumame)
	JEAN WILLIAMS - DAUGHTER 58	b. Mailing Address (Street and Number or Rural Route 8 MADISON ST., WESTMIN	NSTER, MD. 21157
	1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of ery, crematory or other place) UNTY CREMATION 2/9/0	
OUC.	21. Signature of Euneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do		ESTMINSTER, MD. 21157
ਪੂ ਦੂ ਤ Medical Examiner	shock, orbean failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence) Due to (or as a consequence consequence)	oi): fistulue	Interval Between Onset and Death 2 4 4 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
ed by Ph	Part II. Dther significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Completed		10	a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
Medical Certification: To Be Completed by Physician/N		Time of Injury at Work? 28d. De Work? 1 Yes 2 No 28l. Loc	the only one) * C Residence 6 □Other (Specify) escribe how injury occurred cation (Street and Number or Rural Route Number, y or Town, State)
Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	ge, death occurred at the time, date and place, and due	e to the cause(s) and manner as stated.
Me	29b. Signature and title of certifier	29c. License number D 2 5 4 4 3	29d. Date signed (Month, Day, Year) 2/9/06
State istrar	30. Name arc address of person who completed cause of death (Item 23a) JOHN W. MIDDLETON, MD 688 1 31. Date liled (Month, Day, Year) 12. Registrar's Signature	POOLE RD., WESTMINSTE	ER, MD. 21157

			1 - State Registrar	State of Maryla		artment of H tificate of L			ene () () (6	03906
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Elizabeth	G. Filbey				2. Date of Death Month Feb.	1 1, 2006	3. Time of Death 3:00A M
1	Examin		4a. Facility Name (If not institution, give s Carroll Luthers				Location of Death		4c. County of Dea	
H	Funeral Director		5. Social Security Number 6 Sex		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 1.	9. Bi	rthplace (State or Foreign ountry) MD
	anyland ehow	2	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Sa or 28a-f	il Director	MD Carro. 10e. Street and Number 238 St. Mark N		W	estminst 10f. Zip Code 2	1158	10	g. Citizen of What C	
5-0036	n 72 hours after deeth with the Maryland "natural" or Items 23a or 28a-f show sales! Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	l:	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes ⊉☐ No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
0-61212	within 72 ane. then "naf	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. L	lent's Usual Occupa kind of work done of DO NOT use retired Account)	ing 1	6b. Kind of Business Bankin	
yland	ould be filed Mental Hygie arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) George H. Gi	llman				e (First, Middle, M e Irene	aiden Sumame) Pfeffer	
Za	and 2 sho ealth and n 27 le m		19a. Informant's Name/Relationship (Type Ms. JoAnn Barde			•			City or Town, State, imore, M	
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		sition (Name of natory or other place ephard (9)		Oc. Location - City of Ellicott	
Da Da	Departit Depart Import eny in		21. Signature of Funeral Service License	Alanget	S	ykesvil.	le, MD 2	21784 (4	<u>410)–795</u>	Box 195) -1400
	Physician /Medical Examiner		23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Static	Mela,		or respiratory arres	st,	Approximate Interval Between Onset and Death
8/60,	licate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
DOX O	death certii e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ras, r	requires that the een signed by th hould be detache	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	iderlying cause give	on in Part I.			o the cause of death?
L Lec	The law ete hes b page 2 sl	Completed						24a. Was an autopsy performi	ed? prior to death?	utopsy findings available completion of cause of
VII	Physicism: Th this certificete al director, pag	Be	25. Was case referred to medical examiner?	ospital:	7	Othe		h (Check only one		
io uoi	£ 5 =	ation: To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 2 { 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 🔄 INUISING NO	me 5 ☐ Residen 28d. Describe how	nce 6 □Other (Spe v injury occurred	ecify)
DIVISION	To the Hospital or Attending F within 24 hours efter death. To the Funarsi Director: After Apmpletely filled in by the funers	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number.
	in 24 hour the Funsing pletely fill.	edical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kr er. On the basis of examir and manner stated.	nowledge, death nation and/or inv	estigation, in my op	nnion, death occurr	and due to the cau red at the time, dat	use(s) and manner a le and place, and du	s stated. e to the cause(s)
	To To I	Σ	29b. Signature and title of certifier	10		29c. License	number		d. Date signed (Moni	th, Day, Year) 3 2006
11) "		30. Name and address of person who con BINU CHACKO 2	mpleted cause of death (Ite	em 23a) (Type, I Avenue	Print)	minister	MD 21	157	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3	32. Registar's Sign	nature	both				

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:30am Bernard L. Grunder February 8,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mayfield House Assisted Living Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) November 23 1930 **Funeral** Birthplace (State or Foreign Country) 1**M**M 2□F Days Hours Min 215-28-8977 75 Director Baltimore MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examitter roughly be notified at 10d. tnside City Limits MD Baltimore Catonsville Director 1 EYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Fairfield Drive 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 9 Grounds Keeper permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hygi Important: if item 27 is marked other any injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adam C. Grunder Esther Nash ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clementine Constantine / Sister 23 Franklin Tree Court Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Feb. 13. Baltimore MD Meadow Ridge Cemetery 2006 21. Signatur of Funeral Service License Name and Address of Facility

Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final Physician West H disease or condition resulting in death) 2 min /Medical Due to (or as a consequence of): Examiner USTAN Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetat death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) Yes 2 No 9□ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe The law requires Completed 1 Yes 25 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy performed 1 Yes 21 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only/one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification; To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 Director: 6 Could not be determined 3 ☐ Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours To the Funeral pellij 1 Defifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 E. For Au Balt My 21219 DEMM 31. Date filed (Month) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#10b-d, 19b, perFH C352, 2/13/06 TT

State of Waryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** HAST ebruary 6, 2006 4c. County of Death 105 LIOVD HOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner t. Jose Len ter BALTIMORE If Under 1 Year I Under 24 Hrs. 8. Date of Birth (Month, Day, Year), PENNSLY VANIA

Months Days Hours Min. (Month, Day, Year), PENNSLY VANIA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 10XM 2□F Yrs -20-000 Director Usual Residence of Decedent Baltimore 10d. Inside City Limits 10a. State 10c. City, Town or Location Pikesville item 27 is marked other then "neturel", or Items 23s or 28s-f shov other treumstic event, the Madical Examinst must be notified at Tes X No Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 4/2 IGH KOAD USA. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 💆 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other then "ne any injury or other treumatic event, I're Madic once. Elementary/Secondary (0-12) College (1-4or 5+) SSISTANTPRINCIPAL ANNEARUNDEL CO. SCHOOLS + YRS, (MASTERS DEGALE) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETHEL WILSON SR, THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City 95 Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD. 21208 4129 RALEIGH RD DR. LEAH GOLDSBOROUGH HASTY (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY, 02-11-06 WOODLAWN MARYLAND 22. Name and Address of Macility 2140 North Fulton Avenue 21. Signature of Juneral Service Licensee beeph H. Brown Jr. Funeral Home Baltmore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM
Due to (or as a consequence of): **Physician** MINUTES /Medical Examiner CANCER JAN. 04 ADRENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner siclan and burial-transit PROSTATE CANCER 96 TUNE Due to (or as a consequence of): attending physiclan Box 68760 96 RENAL CANCER DEC. Physician/Medical as the l 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the detached 9□ Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ HYPERTENSION, DEMENTIA, ADRENAL 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? LUMBAR HERNIATION INSUFFICIENCY autopsy performed 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes __ 2 💆 No မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARRY S. LINNY M.D. 2116 MARY/AND AVE egistrar's Signature 31. Date filed (Month, Day, Year) FEB 1 3

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Hodges William 19:46 M 2006 ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospita City he Johns Hopkins Sal towork If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs 1₩ 2□F Hours 216-18-5695 Director 85 Yrs. Oct 16, Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Director 1√ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or itams 23a or the Medical Examiner must be 1300 S. Ellwood Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? un 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian unk Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>unk</u> unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk and Mental I 8 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health ar Important: If itam 27 is any injury or other trausonce. Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Fundal Service Lice See Ron 11 1 Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypoxia 1001 /Medical Due to (or as a consequence of): Examiner Premoria Aspiration 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed use as the burial-transit ettending physician and I for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the er 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been si should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Attending Physician: within 24 hours efter death. To the Funerei Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 0 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinuer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 195-000 200K MO USIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Bull more, Mary land 2/18 Scott Berkout 21 Johns Hopkins Hospital, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 3 2006 Registrar

		- State Registrar				Cei	tificate of	Death		Reg.	loss had hed hed	03910
Physici	an	1. Decedent's Name (Fi					Uooka		2. Date of		Day Year	3. Time of Death
/Media	cal	4a. Facility Name (If not	lliam		C		Hooks 4b. City, Town,	or Location	Febru		06, 2006 4c. County of Deatl	7:00 P M
Examir	er	Sinai Hosp	_	vo stroot and trainedry				imore	or Bount		N/A	,
Funeral		5. Social Security Numb				last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. 8. Date of	of Birth	9. Birtl	nplece (State or Foreign untry)
Director		212-24-5969 Usuat Residence of Dec		M 2□F	28	Yrs.			12	2-27-	77	Md.
yland *ow			b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
2 should be filled within 72 hours after deeth with the Maryland and Membal Hygiene. ie marked other then "natural; or liteme 23a or 28e-f ehow aumatic event, the Medical Exactinar must be notified at	ctor	Md.	NA			Ba.	ltimore					1 X Yes 2 □ No
or 28	Director	10e. Street and Number					10f. Zip Code			10g.	Citizen of Whal Co	untry?
0 23a	rai	1647 Norm	nal Ave		Fuer in 11	C 42.1	212		risis 2 (Ossail Ves	- 11-	USA	dan tadin
	Funeral	11. Marital Status 1 Never Married	2 ☐ Married	12. Was Decedent Armed Forces? 1 Tyes 2	•	5. 13. 1	ryas Decedent of I f Yes, specify Cub	oan, Mexica	rigin? (Specify Yes o an, Puerto Rican, etc	or No- .)	14. Race - Ame Black, White	
o is	þ	X 3 ☐ Widowed 4 ☐		1 ☐ Yes 2∜☐ ff Yes, Give Year or Dates:			1□Yes 2□XNo	Specify	r:		Specify: Bla	ick
netra dicta	eted	15. (Specify o	Decedent's E	ducation ade completed)		· (Give	lent's Usual Occu kind of work done	during mos	st of working	16b.	Kind of Business/	ndustry
	Completed	Elementary/Secondar 10th grad	4 1	College (1-4or	5+)		DO NOT use retire			D	ite Aide	
ent,	Be Co	17. Father's Name (First		t)		VV	arehouse		ner's Name (First, Mi			
rked tic ev	ToB	Earl		A.		Hill			Sylvia		Si	mms
ie m		19a. Informant's Name/							per or Rural Route N			
Depertment of Heelth and Menta important: if Item 27 ie marked any injury or other traumatic e 2005.		Sylvia Mil		Mother			3639 ROD sition (Name of	erts .	Place, Ba.	_		21224
.: # ite		1 ₽ Burial 2 □ Cr	emation 3 [Removal from State	0	emetery, cren	natory or other pla	. 1			Location - City or	
ortani injury		4 th Donation 5 ☐ 21. Signature of Funera			Tr	inity	Cem. . Name and Addre		2-14-06	Du Balt	ndalk, M imore, M	d. 1. 21202
e g		> be	or den	, wa	م	,	March F			1101	E. North	Ave.
		23a. Part1. Enter the di shock, or heart fai	sease, or con lure. List only	nplications that caused one cause on each li	the death	. Do not ent	er the mode of dy	ing, such as	s cardiac or respirato	ry arrest.		Approximate Interval Between
rysician	¢ 117	Immediate Cause (Fina disease or condition	d .	a. Asthma								Onset and Death
Medical xaminer		resulting in death)	•	Due to (or as	a consequ	uence of):						
1	ē	Sequentially list condition if any, leading to immediate	ons, fiate	b. Due to (or as	a consequ	uence of):						"
ransit	amine	if any, leading to immediate Electric delying Cause (Disease or injurthat initiated events	y 1	c								
urial-i	i Ex	resulting in death) Last		Due to (or as	a consequ	ience of):						
physicien an s the burial-tr	dica			d								
attending for use as	n/Me	IF FEMALE: 23b. Was decedent pre-	gnant	23c. ff yes, outcome							23d. Date of deli	verv
the atte	icia	in the past 12 mon	ths?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify) _	у			Month	Day Year
ac a	Completed by Physician/Medical	9 Unknown		9□ Unknown								
a pe de	by	Part II. Other significan			ut not resu	uting in the ur	nderlying cause gi	ven in Part				the cause of death?
should	etec	Tunneling co	conary a	rtery						:		·
N	шp									Mas an autopsy performed∂	prior to death?	opsy findings available ompfetion of cause of
rector, page	a)	25. Was case referred to	o medical	1				26 Place	e of Death (Check o	es 2 1	No 15 Yes	2 No
0	To B	examiner? 1 X Yes 2 □ No		Hospitaf:	ent 2X	ER/Outpatien	t 3 DOA Ot	hor	ursing Home 5		6 ☐Other (Spec	ufy)
ctor: After th y the funeral	on:	27. Manner of Death 1 X Natural 5	Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wo	iry al ork?	28d. Desc		fury occurred	
To the Funeral Director: Africompletely filled in by the fur	icati	2 Accident	investigation Could not be	OB Olace of lei				Yes 2		on /C4		ed Dente to
lin by	Certification:	4 Homicide	determined		ury - At ho c. <i>(Specif</i> y	me, rarm, stri	eet, factory, office		City o	on (Street r Town, Sta	and Number or Ru ate)	rai Houte Number,
y fillec	Saic	29a. Certifier 1	Certifying P	hysician: To the best	of my kno	wledge, death	occurred at the ti	ime, date ar	nd place, and due to	the cause	(s) and manner as	stated.
pietel	Medical	(Check only 2\Di one)	Medicai Exa	miner: On the basis o and manner st	f examinal	ion and/or inv	estigation, in my	opinion, dea	ath occurred at the t	me, date a	ind place, and due	to the cause(s)
5	Σ	29b. Signature and title	of certifier	\sqrt{n}			1	se number C.M.E			Date signed (Month oruary 07	• • • •
		PX///	VAN	NIV			0.	. U + 11 + 15	4 •	Ter	Lucity 01	, 2000
			State of the v	4								
		30. Name and address of	of person who	mpleted cause of o	leath (ftem			eet.	Baltimore	, Mar	yland 21	201

			for State Registrar	S	tate of M	laryland / Do	epartmer C <i>ertifica</i> :					giene	16	03911
	Physic		1. Decedent's Name (First Robert Augus		r. Jr.						2. Date of De Month Februa	Day	Year OO 6	3. Time of Death
	/Medi Examii		4a. Facility Name (If not in Greater Bal	stitution, give stree	at and number		4b. City		Location	of Death	100144	4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 186–28–1304	6. Sex 1 € M		ge (<i>In yr</i> s. <i>last birth</i> d	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bird Sept 2	y Year) 9, 1937	9. Birthi Cour Penn	place (State or Foreign ntry) Sylvania
	Maryland a-f show	tor		County Ltimore		10c. City, Town o								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3e or 28	I Direc	10e. Street and Number 100 First Av	7e				Code				10g. Citizen of	What Cou	ntry?
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Medical Exercit at Inust be indiffed at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 2	☐ Married 1	Was Decedent Armed Forces XXes 2 ☐ fYes, Give Year or Dates:	?	13. Was Dece If Yes, spe		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	- 14. Ra Bla	ce - Americack, White,	etc.
Maryland 21215-0036	should be filed within 72 hours and Mental Hygiene. s marked other then "naturel; numetic event, the Medical Ex	Completed	15. D	ecedent's Education highest grade con	n	16a. D (C (i)	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupa ork done o se retired	ation furing mos)	t of work	ing	16b. Kind of I	Business/In	dustry
land 2	e filed al Hygi other vent, I	To Be Co	17. Father's Name (First,) Robert Augus	Aiddle, Last)		Mec	hanic				e (First, Middle, Hucker	Maiden Suma		Company
	nd 2 shou alth and N 27 Is ma		19a. Informant's Name/Re Yvonne Heff]		-						ne MD 2]		, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente Importent: If item 27 Is marked any injury or other treumetic e-	18	20a. Method of Disposition 1 Burial 2 Cren 4 Donation 5 0	ation 3 Remo	val from State	20b. Place of D cemetery, West Ar	isposition (Nai crematory or c undel (me of other place Crema	tory		-2006	20c. Location	-	own, State
Balt	permit. Departi		21. Sonature of Funeral .	lon 16	wol	ed -	22. Name ar Ambros 2719 H	nd Address se Fu lammo	s of Facilit neral nds I	y L Hoπ Ferry	ne of La Rd. La	nsdown nsdown	e e, MD	21227
	Physician /Medical	S.	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ase, for complications. List only one ca	Hepa	ine.	rrhes	le of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
/	Examiner	Examiner	Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or injury	b		shall e		rl						
>,0928	cate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	d	Due to (or as	a consequence of):								
O. Box 6	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 Yes 2 No 9 Unknown	? 1	Live birth	of pregnancy 2 Fetal death t time of death	3 □Ectopic pi 5 □ Other (sp					1	ate of delive	ery Day Year
Records, P.	The law requires that the tee bas been signed by the bage 2 should be detache	ted by PI	Part II. Other significant o	onditions contribu	ting to death b	out not resulting in th	e underlying c	ause give	n in Part I.			bacco use con es 2□No	tribute to th	e cause of death?
al Reco		Completed by								_	24a. Was a autop perfor 1 □ Yes	med2/	Were autoprior to condeath?	osy findings available inpletion of cause of
of Vital	d is	To Be	25. Was case referred to n examiner? 1 ☐ Yes 2 ☑ No	Hospit	tal: 1 🗹 Inpatie	ent 2 ER/Outpa	tient 3 DC	Othe			Check on or	-	ner (Specify	•)
Diviston o	After After funer	Certification;	2 Accident	27. Man er of Death 1 Natural 5 Pending 2 Accident Accident Accident Services Services (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury							8d. Describe h			
Divi	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certif	4 Homicide	/	building, et	ury - At home, farm, c. (Specify)					City or Tow	n, State)		l Route Number,
	the Hosp hin 24 ho the Fune npletely fi	Medical	one)	olcel Examiner: (n: To the best On the basis o and manner st	of my knowledge, do f examination and/o ated.	r investigation.	in my op	inion, deat	d place, a h occurre	ed at the time, d	ate and place,	and due to	the cause(s)
	V Wit		29b. Signature and title of	certifier	eli:	XF)		License		70	2	19d. Date signe フノタノの	d (Month, l	Day, Year)
	141		30. Name and address of p	erson who comple	ted cause of c	leath (Item 23a) (Tyl		mi	ומנו	RO	Su	te 20	9 17	marion 21093
	Sta Registr		31. Date filed (Month, Day,	Year) 3 2006	32. Registr	ar's Signature	berte							

			For Stata Registrar	State of Ma	•	epartment of Health an Certificate of Death	a Mental Hygle	4000	03912
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)		Howell	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al ·	Roberlee 4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or Location of D		4c. County of Dea	4-110
Ş.) 30e		St Agnes	Hospital		Baltimore day) If Under 1 Year If Under 24		O Die	the least (Chaire on Familia
	Funeral Director		5. Social Security Number 216-34-7180 Usual Residence of Decedent	6. Sex 7. Age 1	70 Yr	Months Days Hours	Min. (Month, Day, You 02 02	9. Bli	thplace (State or Foreign buntry)
	yiand how		10a. State 10b. County		10c. City, Town				10d. Inside City Limits
	.89-1 •	Director		NA	Balti		100	. Citizen of What Co	1 XYes 2 No
	tth with the 23a or 2 wat be no		10e. Street and Number 5134 Oaklawn			10f. Zip Code 21207		U.S.A	١.
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Healint and Menlard Hygiene. If Healint and Menlard Hygiene returns 23a or 28e-1 ehow other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married Mar 3 Widowed 4 Divorced	If Yes Give		 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ☒ No Specify: 	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whi Specify: E	encan Indian, te, etc. Black
5-0	"natur	ieted	15. Deceder (Specify only highe	t's Education st grade completed)	16a. E	Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired)	f working 16	b. Kind of Business	/Industry
2121	within jene. r then	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	i+) '	Cashier		ealty Co	mpany
Baltimore, Maryland 21215-0036	should be filed nd Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Robert Turne	Last)		18. Mother's	Name (First, Middle, Manez Bradle		
Aary	2 sho and h is ma rauma	•	19a. Informant's Name/Relations	hip (Type, Print)		Mailing Address (Street and Number of			
ح	1 and Health tem 27 other to		William R. H 20a. Method of Disposition			O5 Ann Street, Disposition (Name of crematory or other place)		c. Location - City or	
E I	Pages ent of nt: if it ry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Conation 5 ☐ Other (S	3 □Removal from State Specify)		Crematory Inc.	2/11/06	Baltin	nore, Md
Balti	pernit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai		21 Signature of Funeral Service	License	AL 2	22. Name and Address of Facility March F/H West 4300 Wabash Av	HERC SHEETO SCIEN		21215
	Physician		shoat, or heart failure. List Immediate Cause (Final disease or condition	complications that caused only one cause on each line.	the death. Do no	ot enter the mode of dying, such as ca	rdiac or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	Xem.a.	ease		year 5
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of				
V	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	·):			
68760,	ificate be executed physician and as the burial-transit	edical E		d					
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	olivery Day Year
- G.	s that i pred by e deta		Part II. Other significant condition	ons contributing to death b	out not resulting in	the underlying cause given in Part I.			to the cause of death?
Oer ords,	require sen sig sould b	ted	HIEM, a	1 . 0			1 ☐ Yes		robably 4 Unknown
Rober II Records,	The law cate has b page 2 sh	Completed by	HYPERT	tension	rren	3.07	24a. Was an autopsy performe	prior to death?	
of Vital	sician: certific irector.	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Out	Other	f Death <i>Check only one</i> ing Home 5 Residen	ce 6 COther (Sa	acity)
sion of	ding Phys th. : After this s funeral di	atlon: To	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date of Inju		Datient 3 DOA 4 11013	28d. Describe how		eury)
Hecu Division	al or Atters after dea all Directors od in by the	Certification:	3 Suicide 6 Could 4 Homicide deten	nined 286. Place of the	jury - At home, fam c. <i>(Specify)</i>	m, street, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
	Hospit 24 hours Funers letely fille	Medicai (29a. Certifier 1 Certifyi (Check only one) 2 Madica	ng Physician: To the best Examinar: On the basis o and manner st	of examination and	death occurred at the time, date and for investigation, in my opinion, death	place, and due to the cau occurred at the time, date	ese(s) and manner a e and place, and du	as stated. re to the cause(s)
	To th withir To th	Me	29b. Signature and title of confidence of the co	Ballo M.	0.	29c. License number		d. Date signed (More	
	5		1	3a110 90	Ocuto	Type, Print) Pro Ave Balt.	6 Formare, Ma	ryland	21229
-	Sta Regist	ate rar	31. Date filed (Month, Day, Year	3 2006 32. Registr	rar's Signature	1.0.	-		
DH	MH 17 Rev 1/2		TED I	a 2000 Car		Signal .			
					OR	IGINAL			

-			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			2006	03913
	Physici /Medi		Decedent's Name (First, Middle, La RUTH	st)	. }	HECHT		2. Date of Death Month FEBRUARY	8, 2006	3. Time of Death 9:20 A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
			SPRINGHOUSE 5. Social Security Number 6. S	7 Ag	e (In yrs. last birthday)	If Under 1 Year	PIKESV			ALTIMORE
2	Funeral Director	1945		□M 2∏F	89 Yrs.	Months Days	Hours Min.	JAN. 28, 1	(ear) 9. Birth Cour	place (State or Foreign htry) MD
	land wo		10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Man,	to	MD BAL1	IMORE	BAL ⁻	ΓIMORE				1 ☐ Yes 2 No
	ith the	Olrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
	ath w	ral	2201 FALLS GABLE				21209			USA
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Iteme 23a or 28a-1 show eny injury or other traumatic event, the Medical Examination in Millian at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] N If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	becify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
50	72 hc	Completed by	15. Decedent's E (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occup	ation during most of work	kina 16	b. Kind of Business/Inc	dustry
121	within ne.	ldm	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired	1)			
	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last,		SALE	-2	18. Mother's Nam	ne (First, Middle, Ma	RETAIL	
lan	ld be ental ked o	To Be	CHARLES		BUR	(F	IDA	io (i nai, imodio, ind	our surrame,	TUCKER
Maryland	shou and M mar umat	-	19a. Informant's Name/Relationship (Type, Print)				ral Route Number, C	City or Town, State, Zip	
	and 2 salth a n 27 ls		SHARON KANTER /	DAUGHTER	2201	L FALLS G	ABLE LANE	- UNIT E	BALTIMOR	E, MD 21209
Baltimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1			osition (Name of matory or other plac ZION CEME			c. Location - City or To	
3a It	epartr epartr nports ny inj		21. Signature of Funeral Service Licer	110				L LEVINSO	N & BROS.,	INC.
	₹0 ≥ € q		ACETO IVI.	wen					KESVILLE,	
6 E.	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each iir	a consequence of):	ter the mode of dyin	g, such as cardiac	or respiratory arrest	Kal	Approximate Interval Between Onset and Death
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of:	ro scle	CIFON			
P.O. Box 6	The law requires that the death certifice has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date ol delive Month	ory Day Year
	quires that en signed t	þ	Part II. Other significant conditions of	ontributing to death be	not resulting in the y	sulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause	
Vital Records,	The law re ate has bev page 2 sho	Completed	Unwhic	Widh	ey m	, wit		24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
Vita V	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hamital.		Lou		th (Check only one)		
o	Phys this ral dir	.T	1 ☐ Yes 2 No 27. Magner of Death	Hospital: t ☐ Inpatie			rsing Hoبياهايي به		e 6 Other (Specify)
o	ding th. : After fune	tlon	1 Netural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work	k? Yes 2 □No	28d. Describe how	injury occurred	
Division of	il or Attending Physician: after death. Director: After this certifica d in by the funeral director, i	ertification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, larm, str c. (Specify)			28l. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edlcal C	29a. Certifier (Check only one) Certifying Ph 2 Medical Example	ysician: To the best of niner: On the basis of and manner sta	examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
)	To the To the comp	Me	29b. Signature and title of certifier	Wm	,70	29c. License	number DO	779 ^{29d.}	Date signed (Month, I	Day, Year)
4	5		30. Name and address of person who	WIJ	eath (Item 23a) (Type,	Print) DO	O Ey	Conv+1	Id; Dalk	WAR PLAN
D _n	Sta Registr MH 17 Rev 1/20		31. Date filed (Month, Day, Year)	2005 32. Rediction	u s Signature	Specific				, , , , , ,
υH	17 nev 1/20	I U								

		_	For State Registrar	* -	of Mary		epartme Certifica			Mental Hy	Reg. No.	306	03914	
	sicia edic		Decedent's Name (First, Midd Barbara		hnson					2. Date of De Month Februar	Day	Year 2006	3. Time of Death 0422	
	mine		4a. Facility Name (If not institution 1634 Cole Str		number)			y, Town, or Balti	Location of Dea			ounty of Dea		
Fune Direc			5. Social Security Number 217–66–3767	6. Sex 1 □ M 2 🛣		In yrs. last birth 51 Yr	day) If Und	er 1 Year			rth ay, Year) 3,1954	0.0	thplace (State or Foreign ountry)	
/land	1	-	Usual Residence of Decedent 10a. State 10b. County	,	10	0c. City, Town	or Location						10d. Inside City Limits	
se Man		ctor	MD			Bal	timore	<u> </u>					1≱Yes 2□No	
h with th		a Dire	10e. Street and Number 1634 Cole Sti	eet			10f. 2	ip Code 2122	23		10g. Citizen of What Country? USA			
inc, intally latter A LATE COORD s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, them 27 a marked other than "natural", or flems 23a or 28a-f ahow		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma. 3 □ Widowed 4 ☑ Divorce	ried 1 Tes	ecedent Eve Forces? es 2 No Give or Dates:	er in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					Race - Ame Black, Whit Specify:		
within 72 ho liene. rthan "natur		Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)		e (1-4or 5+)	16a. C	lecedent's Us Give kind of v ife. DO NOT Homen	vork done o use retired	ation during most of w f)	orking		16b. Kind of Business/Industry Own Home		
12 should be filed within 7 h and Mental Hygiene.		To Be C	17. Father's Name (First, Middle Andrew Lee I							ame (First, Middle Rebecca		,		
and 2 short			19a. Informant's Name/Relation Alanna Cachero		er	1		•		Rural Route Numb Pasadena,			Zip Code)	
permit. Pages 1 end 2 Department of Health a Important: If Item 27 is			20a. Method of Disposition 1 ☐ Burial 2 分 Cremation 4 ☐ Donation 5 ☐ Other (20b. Place of D cemetery, Bayvie	w Crematory of	other place atory	20	Date 010, 006	Balt	ation - City or imore	MD	
Dermit. Departr Importa	once.		21. Signature of Funeral Service	Licensee			22. Name	and Address Mes 0/E	ss of Facility	ens fun Are Ba	Him	tome	Fac 0 2)230	
Physici	an		23a. Part 1. Enter the disease, o shock, or heert failure. Lis Immediate Cause (Final disease or condition	complications the	at caused the	e death. Do no	t enter the m	ode of dyin	g, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
/Medic Examir	al		resulting in death)	Due Due	(or as a co	onsequence of		68 C1 EC4	حدد ن	sour v	40	O U/C		
ficate be executed physicien and state the burial traceit		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and morphale that in but has funeral pincared income director.		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ses 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year				
quires that a signed b		<u>۾</u>	Part II. Other significant condit	ons contributing t	o death but n	not resulting in t	he underlying	cause give	en in Part I.		tobacco use		o the cause of death?	
The law recate hes bee	2	Completed					7.			24a. Was auto perf 1 Yes	an psy ormed? 2 No	24b. Were as prior to death?	utopsy findings available completion of cause of 2 IA No	
ysician s certifi		To Be	25. Was case referred to medical examiner? ★☆ Yes 2 □ No	Hospital:	□Inpatient	2 ☐ ER/Outp	atient 3□ [OOA Oth		eath (Check only Home 5 - Res		₹Other (Sne	cify) Scene	
After this			27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Da	ate of Injury fonth, Day Ye	28b. Tir	ne of	28c. Injun Work		28d. Describe			beene	
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a Hospit 24 hours a Funera		edical	29a. Certifier 1 ☐ Certifyi (Check only one) 1 ☐ Certifyi	ng Physician: To Examiner: On th and m	the best of me basis of ex- anner stated	amination and/	death occurre or investigation	d at the tin	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	nd manner as lace, and due	s stated. e to the cause(s)	
To th Within To th		¥	29b. Signature and title of certific	er .	/		2	9c. Licenso					th, Day, Year)	
7			30. Name and address of person	My D	ause death	h (Item 23a) (To	(De Print)	OCI	Æ		Febr	uary,	5, 2006	
			THEODORE MIK	ing	uedii	(110111 200) (1		11 Pe	enn St r e	et Balt	imore	, Mary	land 21201	
Boo	Stat		31. Date filed (Month, Day, Year	32006	2. Begistrar's	Signature	1							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] For State Registra Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** \mathbf{A}^{M} 31, January 2006 9:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yes, last birthday) Birthplace (State or Foreign Country) **Funeral** -38-12M 20 F Months Days 152 Director Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other then "netural", or items 23s or 28s-f show traumatic event, the Mudical Examples motified at 1 ☐ Yes 2 LINO Director 10e. Street and Number Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Marvland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's To Be should be find Mental Find Mental Financial Mar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health if 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funda Service Licen vans chapel of Martord Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ya lac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2010 210 No 1 Yes 1 ☐ Yes or Attending Physicien: After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending r death. 1 □ Yes 2 □ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a
To the Funeral I
completely filled Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Nam dress person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Manth, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GENEVA MOZMHOT FEBRUARY PM 1205 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST RANDALLSTOWN BALTIMORE HOSATA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **6-25-** Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 217-20-221 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Nymber 10f. Zip Code 10g. Citizen of What Country? ILSA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Black Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during r (Give kind of life. DO NOT Hygiene. (1-40<u>4</u>5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed nent of Health and Mental Hygisht: if item 27 is marked other Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be ٥ Grand 19b. Mailing address (Street and Number State, Zip Code) Daughter 3510 lohnson 20a. Method of Disposition importent: If it 1 Burial 2 Cremation 3 | Removal from State 5 ☐ Other (Specify) reen 4 Donation 21. Signature of Funer Pervice Kidensee Ces 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician rispurator days resulting in death) /Medical Due to (or as a consequence of): Examiner metastati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last conce Physician/Medical Examiner Due to (vi as a consequence of). The law requires that the death certificate be executed for use as the burial-transit ettending physicien and Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by the epage 2 should be detached to 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: Affer this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2000 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo. D 0059 736 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATEN MORTHWEST HOUP MAL 5401 OLD COURT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

		_	For State Registrar	tate of Maryland /	Department of Health an Certificate of Death		giene 0 0 6	03917
1	nysicia Medic	al	1. Decedent's Name (First, Middle, Last) Ohn Rubert As Essilla Name (Host institution in any	Jackson,		2 Date of Dea	18,2006	3. Time of Poeter
3	xamin	er	4a, Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of D	2	4c. County of Death	
	neral ector		5. Social Security Number 316-20-4028 Usual Residence of Decedent	2 ☐ F 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birt	9. Birthpl Coun	ace (State or Foreign try)
Maryiand	Ded at	tor	10a. State 10b. County	10c. City, Toy	rn pr Location Himore		10	0d. Inside City Limits
death with the Maryiand ma 23a or 28a-f show	It he not	Funeral Director	10e. Street and Number 5426 Lesuellen	Avenue	10f. Zip Code 21207		10g. Citizen of What Cou	try?
5-UUSO 72 hours after deat	or other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - America Black, White, e	an Indian, etc.
within 72 houthen." patura	Medical E	ompieted	15. Decedent's Educat (Specify only highest grade of	on 168	Decedent's Usual Occupation Give kind of work done during most of the DO NOT use retired)	working	16b. Kind of Business/Ind	lustry
be filed with tal Hygiene.	event, the	Be Con	Hather's Name (First, Milione, Last)		Driver 18. Myther's	Name (First, Middle),	ransporta Maiden Surname)	ytion
Waryla 12 should h and Men 7 is marke	raumatic	<u>و</u> (a. Informant's Name/Relationship (Type,		b. Mailing Adviress (Street and Numb, ro.	Rural Route Number	0.5	
JOFE, IV	or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem		of Disposition (Name of py, crematory or)ther place)	e. Date	20c. Location City or To	wn, State
Daltimo permit, Page Department of	any injury		21. Signature of Fundryl Service Vicensee	Loue	2 Name and Address of Feding	116/06 ege fur	eral Servi	7/1/3
			23a. Part1. Enter the disease, or complicate shock, or high rational tradium. List only one of immediate Cause (Final	ause on each line.		diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physi /Med Exam	dical		disease or condition resulting in death)	Due to (or as a consequence		ease		
betno	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of}:			
ate be executed bysician and	he burial-tr	dicai Exa	resulting in death) Last	Due to (or as a consequence	of):			
The law requires that the death certificate the has been signed by the attending phys	should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver	ry Day Year
quires that	uld be deta	þ	Part II. Other significant conditions contrib	outing to death but not resulting	in the underlying cause given in Part I.	23e. Did to	obacco use contribute to the	e cause of death?
The lar	oage 2	Completed				24a. Was autop perfor 1 Yes	sy prior to condeath?	psy findings available apletion of cause of 2 No
ysician: ysician:	director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: 1:☑Inpatient 2☐ER/O		Death (Check only on Home 5 Ti Resid	ne) lence 6 □Other (Specify)
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours effer death.	ne funeral	ertification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Time of lnjury at Work? M 1 Yes 2 No		ow injury occurred	,
LIVIS tai or Atters rs efter de	completely filled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Tow	itreet and Number or Rural n, State)	Route Number,
e Hospi 24 hou	etely fill	edicai	29a. Certifier Certifying Physici (Check only one)	an: To the best of my knowledgOn the basis of examination at and manner stated.	e, death occurred at the time, date and pind/or investigation, in my opinion, death o	ace, and due to the occurred at the time,	cause(s) and manner as sta date and place, and due to	ated. the cause(s)
To th withir	сош	Me	29b. Signature and title of certifier Purposed White	Mo	29c. License number		29d. Date signed (Month, D	Day, Year)
	6		30. Name and address of person who comp	200	(Type, Print)	0 21134		
P	Sta egistr	te ar	31. Date filed (Month Day, Year) FEB 1 3 2006	32. Redistrar's Signature	יינטא נידוויייי	<u> </u>		
DHMH 17 F			0 2000		Aprile			
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			Amend Item 24a per verb., G852.02/13/06dhb Certificate of Death Registrar Amend Item 24a per verb., G852.02/13/06dhb Certificate of Death Reg. No. 0 6 0 3 9 8
	Physici	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Frbruary 7 2006 0627 AM
0	/Medic Examin	9 1	la. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 Age (In yrs. last birthday) Months Days Hours Min. 10 - 21 - 1966 99. Birthplace (State or Foreign Country) MID
	aryland •how	J.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 10d. Inside City Limits 1 1 Yes 2 (2) No
	death with the Maryland ma 23a or 28a-f ehow rmest be riculted at	Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
#		Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
17	72 hours after "natural", or its	þ	1 Never Married 2 Married 1 Soves 2 No If Yes, Give 1 Year or Dates: 1 Never Married 2 Married 2 Married 1 Soves 2 No If Yes, Give 1 Year or Dates: 1 Yes 2 Mino Specify: Specify: Specify: 1 Yes 2 Mino Specify: 1 Yes 2
XE 1215-003	within 72 hours after ene. then "netural", or ite	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+1 Owacae NIA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FORKITE DOCUMENTS MC CORMICKS
$\mathcal{M}_{\mathcal{I}}$	Hygi Hygi ther ont, I	To Be Co	12th grade N/A FOREIT Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lula Johnson
US(d 2 should be th and Mental t7 is marked of traumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICOLE Johnson / Wife 1714 Winding Brook Way Balto MD 21244
$\overline{JO}HNSON$ altimore, Maryland			20a. Method of Disposition 20a. Method of Disposition 1 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Completely, crematory or other place) Carnson Forest Date 20c. Location - City or Town, State 20c. Location - City or Town, State Completely, crematory or other place) Carnson Forest
) Baltir	permit. Page Department o Important: If eny injury or		21. Signature of Funeral Service Vicensee No. 1437 22. Name and Address of Facility Vaughn C. Greene Funeral Services 5151 Baltimore Natural Pike Bulto MD 21229
	Physician		23a. Part. Enter the disease, or completations that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of each line.
244 3760,	/Medical Examiner who private transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
0. Box 68	Physician: The law requires that the death certifical this certificate has been signed by the attanding phoral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ds, P.	uires that t signed by Id be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes
l Recor	The law requir ate has been s page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death? Yes 2 \(\subseteq \) No
Division of Vital Records, P.O. Box	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? Tyes
Divis	al or Attens s after death il Diractor; ed in by the	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
(3)	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Medical (29a. Certifying Physician. To the bast of my knowledge, death accumed at the time, date and place, and oue to the cause(s) and in american talled. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
•	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Near J. Name and address of person, no complete to the all death (Item 23a) (Type, Print) Near J. Nat L. 2401 W Belvedere, Baltimore MW
	2		30. Name and address of person no complete to be at death (Item 23a) (Type, Print) Neal J. Nath 2 2401 W Belvedere, Ban Himore MO
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan		rtment of H		-	2000 6 No.	03919
	Physici	an	1. Decedent's Name (First, Middle, Las	it)	, 4			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		MATTIE			DHNS		February	9, 2001	,
	Examin	er	4a. Facility Name (If not institution, give	street and number) HOPICINS 1405F	2,-01		Location of Death		4c. County of Dea	th
			THE JOHNS / 5. Social Security Number 6. Se			If Under 1 Year	LTIMOR If Under 24 Hrs.	8. Date of Birth	o Bir	thplace (State or Foreign
	Funeral Director		233-14-5455	□M 20 F	Yrs.	Months Days	Hours Min.	(Month Day)	'ear) C	ountry) .
			Usual Residence of Decedent					Sq. (S.	() V) RSINIA
	irylan show	_	10a. State 10b. County		y, Town or Loc					10d. Inside City Limits
	8a-f.s	Directo	MARYLAND	BR	altim	1 -	\			1 Yes 2 □ No
	with the	声	10e. Street and Number 3315 Kast Br	11 . 54	4	10f. Zip Code	201	109	citizen of What Co	
	eath ne 23,	Funeral	11. Marital Status	12. Was Decedent Ever in U.		1	224	ocify Ves or No-	14. Race - Am	•
10	fter d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █ No	I .	9	ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black, Whi	
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			17. Father's Name (First, Middle, Last)			MOME	MAKER 18. Mother's Name	(First Middle M		HOME
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Z	d 2 should h and Mer 7 is marke traumatic	၉	19a, Informant's Name/Relationship (T				and Number or Rura	I Route Number, (City or Town, State,	
Š			Vicki L. Luc	2 AS DAUGHTCH	11 0	11		-	Earl .	21085
ore,	es 1 an of Heal of Item 2 r othar		20a. Method of Disposition	20b. P	lace of Dispos				c. Location - City or	
Ē	0 0		¹¹ Burial 2 ☐ Cremation 3 ☐ ¹ 4 ☐ Donation 5 ☐ Other (Specify		dar	4111.0	M Feb	13 2006 6	ICN BUR	NIE HD
Baltimore	permit. Par Departmen Important: any Injury		21. Signature of Juneral Service Licens	See ~	22.	Name and Address	ss of Facility	ININO.	TR. Funes	in Hone 4DZ1ZZ4
Ш	20 E 2 9		(part	Saum		63 45.	onkling 5	street,	BAlto.	4DZ1ZZ4
			23a. Part1. Enter the disease, or comp shock, or heart failure. Ut only	ne cause on each line.	n. Do not ente	r the mode of dyin	g, such as carefac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. HYPOVOL	EMIC	s sto	CK			12 Hours
П	/Medical Examiner		Toolaing in county	Due to (or as a consequ	uence of):		RRHAGE	5		3 DAYS
	STATE OF	ē	Sequentially list conditions,	b. ABDOMIA		HEITO	CKITAGO			3 DAYS
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
8760	5 S S	dicai		. d						
9	death certitics attending ph I for use as th	Med	IF FEMALE:							
Box	death certitic e attending p ed for use as	5								
o.	9 - 7	-10	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna. 1 Live birth 2 Fetal	Ideath 3⊟t	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the d	ysicia	230. Was decedent pregnant		Ideath 3⊟t	Ectopic pregnancy Other <i>(specify)</i>				
σ.	that the cled by the detached	y Physician/Med	in the past 12 months?	1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3⊟t eath 5⊟	Other (specify)		23e. Did loba	Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#19b,perFH,0852,2/13/06 TT
State of Maryland / Department of Health and Mental Hygiene [] [] [6] 03920 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARY 8, 2006 **Physician** KOGAN 9:12 Дм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth DEC. 7, 1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 72 NY 130- 26-3123 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1 DINADEN CIRCLE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No ARMY If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 💢 No Specify. ρ Specify: 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER ENGINEERING permit. Pages 1 and 2 should be filed to Department of Heelth and Mental Hygie Important: If Item 27 is marked other till any injury or other traumatic event, Illu once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALD KOGAN GERTRUDE MURRAY 19b. Maiiro Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 DINANDEN CIRCLE - BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type, Print) SANDRA KOGAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 02/10/2006 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificete be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 □ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA E No Other 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 TYes 28a. Date of Injury (Month, Day Year) After the 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending To the Hospital or Attenums within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2006 25642 Name and address of person who completed cause of death (Item 23a) (Type, Print) author MD 6601 N. Charles Street 32. Redistrar's Signature PEB I 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

C

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Physician:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 03923 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** February 07 01:00 M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4b. City, Examiner tookins 6. Sex Himore N/A Johns Hospital Dal-If Under 1 ne 8. Date of Birth (Month, Day, Year) AUG. 8, 1922 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrst last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1□M 2□F Yrs CANADA 83 Director 217-12-9562 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours atter deeth with 1 ann of Health and Mental Hygiene.
ant: if item 27 is marked other than "naturat", or itema 23a or item toy or other traumatic avent, its Medical Examinat manta.
ury or other traumatic avent, its Medical Examinat manta. 4001 OLD COURT ROAD #211 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No NAVY
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 □ Divorced ear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF PUBLIC RELATIONS CHARITIES-MARCH OF DIMES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLAUSTEIN REBECCA SKLAR LOUIS ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 360 BLYMIRE ROAD - DALLASTOWN, PA 17313 TERRY LAZARUS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 02/10/2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner IOSTY idiu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Obstr Monic Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has After this certifice funeral director, J 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X inpatient ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No nours efter death.

neral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the th 29b. Signature and time of certifier 29c. License number 0 Medical Doctor

DHMH 17 Rev 1/2001

State

Registrar

George

31. Date filed (Month, Day, Year)

ORIGINAL

Hospital, 600 North Wolfe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Ho,

FEB 1

Johns Hopkins

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ERSERG 3:57 AM February HARRY 09 2006 /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The N/A Hospital ity JORMS HOPKins 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) NOV. 22, 1908 Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Hours 150-07-1189 97 Director Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the maryiar nent of Heetih and Mental Hygiene. ant: If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow ury or other treumatic event, If a Madical Examiner traint ke notified at Director MONTGOMERY CHEVY CHASE 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5610 WISCONSIN AVENUE #1003 20815 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No
1f Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE DEVELOPER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MYERBERG ANNA DUBOVSKY NATHAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heelth at
Important: If Item 27 is
any injury or other treu 5309 AUDUBON ROAD - BETHESDA, MD 20814 ELIZABETH DUBIN / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 02/10/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48 Rout Immediate Cause (Final disease or condition resulting in death) Rours **Physician** Esophage O Due to (or as a consequence of): /Medical Examiner gastric mass b Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (ur as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ certificete has been signi rector, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No Division of Vital 1 Yes 2 XN Attending Physician: 25. Was case referred to medical examiner? funerel director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending To the Frospins after death.

To the Funeral Director: After the funeral by the f 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ö Certifying Physician: To the best of my knowledge, death eccurred at the time, date and place, and due to the nause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe February 09,2006 crobi Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATT MORE, MARYLAND 2/2 ospital PARIZAD TORABI Johns Hockins 600 NORTH WOL 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2006 Registrar

			For State	ype or Prin State of Ma		d / Depa		of He	ealth and		al Hyg	iene ()	egible.	039	25
	Physici		1. Decedent's Name (First, Middle, Last) LEONID			-	RKMAN	OIL	realii		ate of Dear	Day	Year 2006	3. Time 6	
	/Medio Examin		4a. Facility Name (If not institution, give st Sinai Hospitel	of Bal	Hma		13	ait	Location of Dec	ath C		4c. Co	unty of Deat	N/A	
	Funeral Director		5. Social Security Number 216-47-2858 Usuel Residence of Decedent	M 2□F	56	Yrs.	If Under Months	Days Days	Hours Min	FE 8. D	ate of Birth donth, Day B . 5 , I	950	9. Birti Co.	BELA	or Foreign RUS
	death with the Maryland rms 23a or 28a-f show	Director	MD BALTIM	10RE	10c. City, Town or Location BALTIMORE 10f. Zip Code					_	10g. Citizen of What C				S 2 No
	eath with t	erai Dir	7016 TOBY DRIVE	2. Was Decedent I	Ever in 11 9	13 1			21209				Race - Ame	BELA	RUS
9	ours after di ral', or item Examinar	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			f Yes, spec		spanic Origin? n, Mexican, Pue Specify:	nto Ricar	n, etc.)		Black, White		E
1215-003	be filed within 72 hours after death with the Marylar tall Hygiene. tal Hygiene. to other than "natural; or items 23a or 28a-1 show and other than "natural; or items 23a or 28a-1 show award. The mail rem	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		⁺⁾ 5+	life. I	dent's Usua kind of wor DO NOT us PRES	k done d e retired)	uring most of w	rorking			of Business/		
Maryland 2121	2 should be filed w and Mental Hygier Is marked other th eumatic svant, in	To Be Co	17. Father's Name (First, Middle, Last) ISAAK			MARK	MAN		18. Mother's N		st, Middle,	Maiden Su	mame)	LEVI	N
	# 12 B	•		WIFE	205 8	7016	TOBY	DRI	Number or I		ORE,	MD 21	.209		
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition 1 [X] Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		ce	ace of Dispo metery, crer SINA	natory or of	ther place ETER	Y 02/	10/2	006	OWI	NGS M	ILLS,	MD
Ba	permit. Departi Import sny inj		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	Zu-	the death	8	900 R	EIST	s of Facility S ERSTOWN p. such as card	I ROA	D - P	IKESV			ate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ESPH Due to (or as	094	cul l		ces	Hen	lorv	hage			Onset and	
68760,	executed an and rial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	·			010	W C.		čer			24	rs
P.O. Box 6	the death certificate be ex y the ettending physicien ched for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 minths? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pro					230	I. Date of del Month	very Day	Year
	w requires that the de been signed by the e should be detached f	Ď	Part II. Other significent conditions conditions.		ut not resu	Iting in the u	nderlying ca	ause give	n in Part I.				contribute to		death?
I Reco	: The law re cate has be page 2 sho	Completed								-	24a. Was a autop perfor 1 ☐ Yes	sv	death?	topsy finding completion of 2 \(\text{No} \)	s availabte cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the eltending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural 5 Pending 2 Accident investigation	ospital: 1 npatie 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 Nursing	Home	5 Resid		Other (Speccurred	cify)	
Divis	s after dea s after dea el Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, sti	reet, factory	, office			ocation (S City or Tow		Number or Ru	ıral Route Nu	ımber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best er: On the basis of and manner of	f examinat	wledge, deat ion and/or in	vestigation,	in my op	inion, death oc	ice, and o courred at	the time, o	date and pl	ace, and due	to the cause	
)	To To con	2	29b. Signature and title of certifier	al				Res	- OO C)		_	uq vq		
2	\ 			TALI S	1191	hus		_ 0	of B.	ltir	nure		0		
. 1	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 3 2	32. R Gistr	ar a dignat	A A	speck	9							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10, 2006 O'Sullivan Feb. Marjorie Ann 4:45P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5704 Mineral Hill Road 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1923 Sykesville Carroll 5. Social Security Number Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 JF 219-18-3407 Director Usual Residence of Decedent tiled within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5704 Mineral Hill Road 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12 rmit. Pages 1 and 2 should be tiled w pertment of Health and Mental Hygia portent: If item 27 is marked other ti y injury or other traumatic event, ID. Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Francis Delamater Sarah Maurice Bourne 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harry O'Sullivan (Son) 308 Neale Ct., Sykesville MD 21784 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 2/15/06 Baltimore, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) Muan Hais oc. Sykesville, MD 21784 (410) 795-1400 23a. Part1. Enter the disease, or complication. Do to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death allb (adde Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Vision of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes 3 Probably 4 Unknown 2 🔲 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) tuneral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Atter or Attending Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the t 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide To the Hospital 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - MD ZUST 31. Date filed (Month, Day, Year) State Registrar

			1 - State Amend Item#18 per	FH G852 2/13/06	tificate of Death	Mental Hygi Rei	eng 006	03927			
H	Physicia	an	Decedent's Name (First, Middle, Last) MTTT.	LIAM EDWIN O	'GRADY	2. Date of Death Month	Day Year	3. Time of Death			
)	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Deat	FEB. 9	4c. County of Death	2:39 P M			
			CARROLL HOSPITAL C	ENTER	WESTMINSTER		CARROL:	<u>.</u>			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day,	(ear) 9. Birthp	place (State or Foreign			
	Director		212-34-6291 IAJM 2LJ Usual Residence of Decedent	69 Yrs.		5/16/1	936 VIRG	INIA			
	yland 10W		10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits			
	a-f et	ctor	MD Carroll	Westmin	ster			1 ☐ Yes 2 No			
	or 28	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?			
	death with the Maryland me 23a or 28a-f ehow Frivet be nullined at		721 ROLLING RIDGE		21157		USA				
_		Funeral	1 Never Married W Married 1 KTV	AC 2 NAZOD TIANT	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,				
5	hours after death with the Marylan Lural', or iteme 23a or 28a-f ehow al Eneminal must be nutified at	þ	3 Widowed 4 Divorced Year	Give or Dates:CONFLICT	1 ☐ Yes 2X No Specify:		Specify: WH	IITE			
12-0036	E 3 1	Completed	15. Decedent's Education (Specify only highest grade complete	16a. Deced	dent's Usual Occupation kind of work done during most of wo	deina 1	Bb. Kind of Business/In	dustry			
2	within 72 ene. then "nai	mple	Elementary/Secondary (0-12) Collect	ge (1-4or 5+)	DO NOT use retired) PAINTER		ONSTRUCTI	ON			
2 0	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)			me (First, Middle, Ma					
all	uld be Mental Irked o	To Be		ALEXANDER O'G	RADY MAUDE	ARCHIBA	LD SUDDUR	тн			
aZ	shound M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or Ri	ural Route Number,	City or Town, State, Zip	Code)			
ž	end 2 salth a n 27 ic		MARY E. O'GRADY -	WIFE 721 R	ROLLING RIDGE 1	OR.,WEST	MINSTER, N	ID 21157			
ore,	Pages 1 end bent of Healt int: If frem 2 iry or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal fi	20b. Place of Dispo cemetery, cren	natory or other place)		Oc. Location - City or To				
Baitimor	교문으로		4 ☐ Donation 5 ☐ Other (Specify)	LAKE VIEW	MEM. PARK 2/1	4	LDERSBURG				
e n	Depermit Deper Impor eny in		21. Signature on Funeral Pervice Licensee		. Name and Address of Facility $_{ m FI}$						
			23a. Part1. Enter the disease, or complications the shock, or feart failure. List only one cause	nat caused the death. Do not enti-		··		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	· Cul ·	ic obstructe ful	HUMMLY DI	XO V	Onset and Death			
	/Medical Examiner		resulting in death)	to (or as a consequence of):	,		au c				
	Lammer	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Multiput Mutushatic Skin Cancez Due to (or as a consequence of):								
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<u>,</u>	be executed sicien and burial-transit	Examiner		to (or as a consequence of):	^						
P8/P0	death certificate be execut e attending physicien and od for use as the burial-trar	edical	d	home kulne	y Disease						
	entifica ling ph e as tl	Med	IF FEMALE:								
X Q Q	eath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ory Day Year			
j	that the de ned by the a detached t	Physician/M		nknown	Other (specify)						
1	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions contributing	to death but not resulting in the ur	ndertying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?			
ğ	en sig	edt				1 ☐ Yes	2 □ No 3 □ P1 0b	ably 4 🗀 Unknown			
Vital Records,	law requ as been 2 shouk	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of			
<u> </u>	The la	Соп				performe 1 ☐ Yes 2	ed? death?				
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:		0#==	ath (Check only one					
5	Phys r this ral di	2	1 163 2 5 140	☐ Inpatient 2☐ ER/Outpatien ate of Injury 28b. Time of	1 3 DOA 4 INUISING P	fome 5 ☐ Residen	ce 6 Other (Specif	y)			
<u>0</u>	Attending I r death. ector: After by the funer	atlor	1 ☑Natural 5 ☐ Pending (final strength of the	ate of Injury Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,				
DIVISION	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. P	lace of Injury - At home, farm, stri uilding, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	net and Number or Rura	I Route Number,			
5	ital or A										
	Hospital	Medical	(Check only 2 Medical Examiner: On the	o the best of my knowledge, death he basis of examination and/or inv manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occurred	e, and due to the cau urred at the time, dat	ise(s) and manner as s e and place, and due to	tated. o the cause(s)			
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)			
			Shall X	an,	021015		2109106	0			
1	10		30. Name and address of person who completed		Print)						
) \	1				or Westernste	R HO 2	1157				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3 2006	7. Registrar's Signature	de la						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Physician 12:30am м Mildred Peterson February 9,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Heartland Assisted Living Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 😿 F 092-09-6654 95 Yrs. Director Sept.17,1910 NY Usual Residence of Decedent 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at MD Howard Ellicott City 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3004 North Ridge Rd. #h-103 21043 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: White Completed by 3 MWidowed 4 ☐ Divorced neturai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 ges 1 and 2 should be filed v t of Health and Mental Hygie if item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johann Betz Catherine Marie Hoefener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Peterson / Son 5 Keller Road Baltimore MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Panama City.Florida 2/16/06 Forest Lawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. disello Immediate Cause (Final neuro degenerative Physician Vleam disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1107/11th Sequentially list conditions any, leading to min adiate cause. Enter Underlying Cause (Disease or injury Qualto for as a nonsecuança or Examine use as the burial-transit requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Yes 2 No 3 Probably 4 Unknown pieted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an certificate has autopsy performed? 1 ☐ Yes filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 Yes 2 YNo 1 Inpatient 2 ER/Outpatient 3 DOA this Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending after death. 1 ∏ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospitei 29a, Certifier 1 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26631 MO G, 5006 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) Brun Adi _ 51kridge 8186 MY MILLUSS Canh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 3 2006 Registrar

			1 - For State Registrar	ate of Maryland / Dep	partment of Health and Mertificate of Death		29 006 03929		
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Zarfa 4a. Facility Name (If not institution, give stree	Peles	4b. City, Town, or Location of Death	February	Oay Year 12:31 P M		
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		tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or	Location Pikesville	Jan. 9, 1.	10d. Inside City Limits 1 ☐ Yes 2X No		
	uth with the M 23a or 28e-f	Funeral Director	10e. Street and Number 203 Sherwood Avenue		10f. Zip Code 21208		Citizen of What Country? Bosnia		
9003	within 72 hours affer death with the Maryland ene. then "naturel", or items 23a or 28e-f show ha Mudical Evartinel, must be notified at	by	1 Never Married 2 Married 1 3 Whidowed 4 Divorced	Yes 2X No Yes, Give ear or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White.		
1215-	filed within 72 hours Hygiene. Ither then "naturel" int, the Medical Ex	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	nnpleted) 16a. Dec (Giv Iollege (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) Homemaker	ting 16b.	Kind of Business/Industry Own Home		
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	1 and 2 steelth ar		19a. Informant's Name/Relationship (Type, F Ivana Duspara/Grando 20a. Method of Disposition	laughter 163	Cherrydell Road, (Catonsville			
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ords, P	w requires thet the been signed by the should be detached.		Part II. Other significant conditions contribu Splenectomy //Critic	1 11	underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
ital Rec	The law ate hes b page 2 sl	Be Completed by	Adult manasmus // A Hypertension // Nons 25. Was case referred to medical examiner?	nti phospholipid e mall cell lung ca		24a. Was an autopsy performed? 1 Yes 2 You	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To E	27. Manger of Death 1 Natural 2 Accident investigation 2 Stricted 6 Could get be	a. Date of Injury (Month, Day Year) 2 EH/Outpatie 2 28b. Time Injury	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	me 5 ☐ Residence 28d. Describe how inj	ury occurred		
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)	To the P within 24 To the F complete	Medical	E Intodicui Cantillier.	in the dask of examination and/or in manner stated.	29c. License number	29d. D	Pate signed (Month, Day, Year)		
100	(e Sta	te	30. Name and address of person who comple J Boston Nort 31. Date filed (Month, Day, Year)	ned cause of death (Item 23a) (Type hwest Hosp) to		llstown,	Maryland 21133		
12/2	Registr	ar	FFR 1 2 2006	Rose H	land a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** EACE elomany 12:30A M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kanda If Under 1 Year Hospita If Under 24 Hrs. th Battimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 98 Months Days Hours 1 ☐ M 2 💢 F Director 10a. State 10b. County 10c. City, Town or Locatio 10d. Inside City Limits or Items 23a or 28a-f show directors the notified at 1 Yes 2 No Director 10e. Street 10g. Citizen of What Country? Completed by Funeral 11. Marital Status 12. Was Decedent E Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ō Specify: The Medical Exac Black 3 Widowed 4 ☐ Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) kind of work done during most of working DO NOT use retired) 27 ie marked other then traumatic event, I'e Ms Oy (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma To Be (Type, Print Health tem 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of important: if it eny injury or o once. 1 ☐ Burial 2 [Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signiture of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician men mom /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Yes 2 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only dne) Hospital: 1X Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP who completed cause of death (Item 23s) (Type, Print) 30 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perPhy (3852m2 13.06 TT)
State of Maryland / Department of Health and Mental Hygiene Amend item#1, perPhy, C852, 2/15/06 Tertificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Seymour J. Penement Seymour J. Ponemone Day 9 2006 **Physician** 3:39 A M February Mone /Medical c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randa listown Northwest Hospital Cent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN. 4,1921 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F NY 85 Yrs 119-03-9628 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No by Funeral Director RANDALLSTOWN BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21133 USA 3532 CABOT ROAD death 12. Was Decedent Ever in U.S.
Armed Forces?
1 XX Yes 2 □ No ARMY
1f Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 0 WHITE 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CHEMICAL ENGINEER WESTINGHOUSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be rin and Mental F. HIRSCHHORN PONEMONE YETTA **JOSEPH** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if flem 27 is any injury or other traum 3532 CABOT ROAD - RANDALLSTOWN, MD 21133 SHIRLEY PONEMONE / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 02/11/2006 TOWSON, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neart atherosclerotic **Physician** ears /Medical Examiner betei Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner transit or Attending Physician: The law requires that the death certificate be executed Saundice Due to (or as a consequence of). O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month - Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 TUnknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 □ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pendina 1 Yes 2 No death. neral Director: A filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours : To the Funeral 29a. Certifier 1 ☑ Certifying Physician: To the bast of my knowledge, death concret at the time, date and blace, and due to the squae(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9,2006. D56418 February and will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Read, Randallstown, MD 211 OldComt 5401 Tonya Mason MD 32 Aegistrar's Signature 31. Date filed (Month Some of State 2006

DHMH 17 Rev 1/2001

Registrar

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	Funeral Director		5. Social Security Number 6. S 6. S 6. S 7. Social Security Number 1 8. S 1 Usual Residence of Decedent	ex 7. Age (III	n yrs. last birth	nday) If Und Month		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da OCT, 2	y, year) 9.8 4/923 Sx	irthplace (State or Foreign Country) ATH CAROLINA
	72 hours after death with the Maryland netural, or Items 23a or 28a-1 show diest Examiner must be notified at	Funeral Director	10a. State 10b. County MARYLAND N/ 10e. Street and Number 11. Marital Status 12 Never Married 2 Married	ALTIMORE S 12. Was Decedent Eve Armed Forces?	1 : / 1 /	101.2	Zip Code	2/2 panic Origin? (S Mexican, Puen	Pecify Yes or No o Rican, etc.)	10g. Citizen of What (5 A , nerican Indian,
215-0036	within 72 hours af lene. then "netural", or the Maulcal Exami	Completed by F	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	1 Yes 2 No If Yes, Give Year or Dates: ducation ide completed)	16a. [Decedent's Us	sual Occupati	Specify: on ring most of wor	rking	Specify:	BLACK s/Industry
Maryland 2121	be filed ital Hygi of other	To Be Com	17. Father's Name (First, Middle, Last) THOMAS		OBIN		EST		1	PRIVATE Maiden Sumame) T/L	FAMILIES MAN
Baltimore, Mary	les 1 and 2 shi of Health and If item 27 Is m or other treum		19a. Informant's Name/Relationship (LAURA SMITH 20a. Method of Disposition 1 Burial 2 Cremation 3 L 4 Donation 5 Other (Specification)	Type, Print) (DAUGHTE Permoval from State		Mailing Addre	MARI			RESVILLE M. 20c. Location City of	10,21
Balti	permit. Pag Department Important; any injury o		21. Signature of Funeral Septice Licer	isee WM	PIC (R)	39	and Address	FULTO	ROWN NAVE.	JR. FUND BALTO, K	ERAL HOME
	Physician and /Medical Examiner	i Examiner	23a. Part. Enter the disease, or com shock, or Irear failure. List only Immediate Pause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of	<u>CA</u>			c or respiratory dr	rest,	Approximate Interval Between Onset and Death
P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death e of death	3 Ectopic 5 Other (specify)	in Port I	23a Did t	23d. Date of d Month	Day Year
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5	V		30. Name and address of person who of	on the	40 :	の一年	8 N.	ROP .	LLST	7 400	1051133
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 3 200	Registrar's	Signature	made					

		1 - State Registrar	partment of Health and Ment Certificate of Death	Reg. No. UUD UJ	933
Physic /Med		1. Decedent's Name (First, Middle, Last) Mary Leona Ridgley	N	late of Death flooth Day Year 25.00, 10 2006	ne of Death
Exam	iner	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster	c. County of Death Carroll	
Funera Directo		5. Social Security Number 218-24-8937 6. Sex 1 M 2 F 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd)	Months Days Hours Min. (A	ate of Birth Month, Day, Year) 9. Birthplace (State Country) pt 17 1928 MD	ate or Foreign
Maryland febow	jo.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o MD Carroll Sykest			de City Limits Yes 2 X No
h with the 13a or 28a	Funeral Director	10e. Street and Number 218 Obrecht Road	10f. Zip Code 21784	10g. Citizen of What Country?	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "nature!", or iteme 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give 4 Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar 1 Yes 2 No Specify:	Yes or No- n, etc.) 14. Race - American Indian Black, White, etc. Specify: white	n,
21215-0036 d within 72 hours af giene. er then 'naturel', or ine Wedical Exern	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of working le. DO NOT use retired) memaker	16b. Kind of Business/Industry	
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2 5 € 2 5	2	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rural Route 218 Obrecht Rd.,	ite Number, City or Town, State, Zip Code)	1784
Baltimore, permit. Pages 1 ar Department of Hea Important: if them eny injury or othe		INCIDUITAL 2 CONTINUES S CHANGOVALITORI SCALE	sposition (Name of crematory or other place) field Cem. 2-15-0 22. Name and Address of Facility Haigh	20c. Location - City or Town, State 6 Sykesville, M t Funeral Home &	1d
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	P.O. Box 195 Sykes enter the mode of dying, such as cardiac or resp	ville, Md 21784 piratory arrest, Approxi	
ate be executed xi hysician and mid-transit to burial-transit to b	ical Examiner	Sequentially list conditions, 1 ary, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Cus to (or as a consequence of): c. Due to (or as a consequence of): d.			
BOX 50 sath certific attending pofor use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moetrs? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Dectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day	Year
COTGS, P.O. **requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause 1 ☐ Yes 2 █ No 3 ☐ Probably 4	
al Reco	Completed			24a. Was an autopsy finding prior to completion death? 1 Yes 2 1 45	of cause of
LIVISION OT VITAL HECOTES, To the Hospital or Attending Physician: The law requires t within 24 hours effer death. To the Funeral Director: Affer this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification: To Be	27. Manner of Death 1	e of 28c. Injury at 28d. [ry Work? M 1 Tyes 2 No	sck only one 5 Residence 6 Other (Specify) Describe how injury occurred ocation (Street and Number or Rural Route I	Musther
Spital or A cours efter neral Direction by	ai Certif	4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d.	eath occurred at the time, date and place, and d	ity or Town, State)	
To the Hospital within 24 hours e To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	r investigation, in my opinion, death occurred at 29c. License number	the time, date and place, and due to the cause 29d. Date signed (Month, Day, Yea	ar)
le '		30. Name and address of person who completed cause of death (Item 23a) (Ty, 138) Rogress Way Suit 18	De Print) Ecocassing Wi		
Regis DHMH 17 Rev 1/		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hours	·	
		OR	IGINAL		

		1 - For State Registrar	State of Marylan	d / Depa	artment o	of Health and of Death	-		-	03934
		1. Decedent's Name (First, Middle, Las	")				2. Date of De		. V	3. Time of Death
Physic /Medi Examii	cal	Grace 4a. Facility Name (If not institution, give	S. Rykiel street and number)		4b. City, To	wn, or Location of De	Feb.	9 , 4c.	Year 2006 County of Dear	4:15AM ^M
LXaiiii	161	104 Pleasant R)6	Owi	ngs Mill	S	В	altimo	re
Funeral Director		5. Social Security Number 6. Se 11			If Under 1		rs. 8. Date of Bir	th ay, Year)		hplace (State or Foreig untry) MD
land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
the Mary 28a-f eh	Funeral Director	MD Baltin	more	Ow	ings	Mills		10a. Citi	zen of What Co	1 Yes 2 No
3a or		104 Pleasant R	idge Dr. #20)6		1117			US	·
death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?			t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No	D-	14. Race - Ame	nican Indian,
ours after rai', or its Examina	Þ	1 Never Married 2 Married 3 Nover Married 4 Divorced	1 Yes 2 TNo If Yes, Give Year or Dates:		Tes, specify		erto nicari, etc.)		Black, Whit	USA
be filed within 72 hours after death with the Maryland tall Hygiene. Ind Hygiene. Indoorher then "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	lent's Usual C kind of work o DO NOT use	done during most of v	vorking	16b. Ki	nd of Business	Industry
200	် ၁	12		H	iomema			ļ	Domes	tic
should be filed within the Mental Hygiene. marked other then matic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden	Sumame)	
d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	2	Alfredo Graz 19a. Informant's Name/Relationship (T		19h Mailir	Address /S	treet and Number or	rie Glo			Zin Code)
and 2 sho ealth and m 27 is m		Mrs. Marlene K		1:				-		Md 21784
- I 2 5		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of	Date		cation - City or	
Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	demoval from State	-	•	emation	2/11/06	Sv	kesvil	le MD
permit. Pages 1 a Department of Hec Important: if Item eny Injury or othe		21. Signature of Funeral Service Licens	Haight	22 H	ATCHT	Address of Facility FUNERAL ille, MD	HOME 8	CH	APEL (Box 195)
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ent	er the mode of	f dying, such as card	iac or respiratory a	rrest.	01_193	Approximate Interval Between
Physician /Medical Examiner sicieu and ponial-trausit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of the consequence o	uence of):	locata.	- Luc	. D. s.	CEE		
· 2 × 9	ical		d							
The law requires that the death certifica ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3	Ectopic pregi Other (speci			2	23d. Date of de Month	ivery Day Year
uires that I signed by		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying caus	se given in Part I.		tobacco u Yes 2[the cause of death?
The law requires the state has been signed page 2 should be of	Completed by							psy ormed?	death?	utopsy findings available completion of cause of
rsician: The secretificate	0	25. Was case referred to medical				26. Place of D	leath (Check only	2 No	10163	NO NO
	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA	Other: 4 Nursing	Home 5 Aes	idence (6 □Other (Spe	cify)
		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	Injury at Work? 1 Yes 2 No	28d. Describe			
al or Attending safter death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	eet, factory, o	ffice	28f. Location (City or To	Street and wn, State	d Number or Ri)	ural Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at i	he time, date and pla my opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
To t To tt	Σ	29b. Signature and title of certifier			29c. L	icense number		29d. Dat	e signed (Mont	h, Day, Year)
6		30. Name and address of pirson who c	ompleted cause of death (Item		Print)	02908	5	Fe	o io	2006
9		Allen J. Ch.			310	000 00	or Re	60	5	4//3>
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa		-					

			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygien	.000 0000
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last) O ALO Jz 4a. Facility Name (If not institution, give s	Treet and number)	4b. City, Town, or Location of Dea	2. Date of Death Month Da	3. Time of Death Year 1 200 8:00 6:0
	Funeral Director		5. Social Security Number 6. Sex 317 1	M 20 F 83	rs. FORST HIJI Hunder 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
	ms 23a or 28a-f show	ector	10a. State 10b. County PARIAN HARFER 10e. Street and Number	10c. City, Town	11.H 72		10d. Inside City Limits 1 ☐ Yes 2☑ No
9	or Ita	by Funeral Directo	309 FOREST VALL	2. Was Decedent Ever in U.S. Armed Forces? 150 Yes 2 No If Yes, Give Year or Dates:	10f. Zip Code 3 0 50 13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	j	14. Race - American Indian, Black, White, etc.
	I Hygiene. other than "natural", rent, the Medical Ext	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work done during most of work life. DO NOT use retired)	me His	Kind of Business/Industry MYLANO STATE AWAY ACMINISTRATION
laryianı	and Mental H is marked off	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type)	DHRGACK 19b.	18. Mother's Na A Mailing Address (Street and Number or R	tural Route Number, City	OPER
altimore, IV	perinit. Teges it and 2 should be littled writing Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the MDD.		20a. Method of Disposition 1 Seburial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Furnital Perivice License	emoval from State	Disposition (Name of y, crematory or other place)	Date 20c. L	ocation - City or Yown, State
	lmp lmp any		Last King		22. Name and Address of Facility EXAMPTERAL Output	C O O O	Approximate Interval Between Onset and Death
	hysician /Medical Examiner	ır	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	4/1	Cella Ca	e mante
0,00,	ohysician and the burial-transit	dical Examiner	frank, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	0	J	
o you .	e attending p	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Dectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Cords, r.O	been signed the should be det	by P	Part II. Other significant conditions conf	ributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?
ביים ביים	ate has b	e Completed	25. Was case referred to medical		26 Place of De	24a. Was an autopsy performed? 1 ☐ Yes 2⊅ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5	h. After th funeral	atlon; To B	examiner? 1 Yes 211 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	patient 3 DOA Other: 4 Nursing	Home 3-5 Residence 28d. Describe how inju	
DIVISION OF THE PROPERTY OF TH	within 24 hours after death To the Funeral Director: completely filled in by the	ai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	City or Town, State	
10.04	within 24 hours a To the Funeral I completely filled	Medicai	(Check only 2 Medical Exeminone) 29b. Signature and title of certifier	er: On the basis of examination and and manner stated.	29c. License number	urred at the time, date an	d place, and due to the cause(s) ate signed (Month, Day, Year)
10	7		30. Name and address of person who cor	npleted cause of death (Item 23a) (Fahn \$500	Type, Print) A hoch Rave	Nurd 1	RUARY 13 2006 Re 14 Ml 21239
1	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 3 2006	2. Registrar's Signature	per le	. , , , , , , , , , , , , , , , , , , ,	

cial Security Number 6.5c 11 2 - 3 3 1 6 11	ALA a street and number) AND AND AND AND AND AND AND AN	ity, Town or Location BALTIMORE 10f. Zip J.S. 13. Was Deceded If Yes, spectors 1 Yes 2 Yes 2 Yes 16a. Decedent's Usua Give kind of wor	Code 21231 lent of Hispanic Origin? (rify Cuban, Mexican, Pue	s. 8. Date of Birth (Month, Day, Yea JAN . 18,	1921 MAR	YLAND Od. Inside City Limits 1 XYes 2 □ No
The Johns High Stall Security Number 6. Second Security Number 6. Second Security Number 10b. County 1	REET 12. Was Decedent Ever in tagent Armod Forces? Was 2 Do If Yes, Give Year or Dates: 194	ity, Town or Location BALTIMORE 10f. Zip J.S. 13. Was Deceded If Yes, spectors 1 Yes 2 Yes 2 Yes 16a. Decedent's Usua Give kind of wor	Tyear If Under 24 Hr Days Hours Min Code 21231 Jent of Hispanic Origin? (Infry Cuban, Mexican, Pue	s. 8. Date of Birth (Month, Day, Yea JAN 18,	N/A N/A 9. Birthpl Count 1921 MAR Citizen of What Count U.S.A.	YLAND Od. Inside City Limits 1 XYes 2 □ No
cial Security Number 6.5c 11 2 - 3 3 1 6 11	7. Age (In yrs 8 10c. C) REET 12. Was Decedent Ever in Lamed Forces? NEW S. Give Year or Dates: 194 Lucation de completed)	ity, Town or Location BALTIMORE 13. Was Decedent's Usua (Give kind of wor	Tyear If Under 24 Hr Days Hours Min Code 21231 Lent of Hispanic Origin? (city Cuban, Mexican, Pue	JAN. 18,	9. Birthpl Count 1921 MAR MAR	YLAND Od. Inside City Limits 1 XYes 2 □ No
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ather's Name (First, Middle, Last) OSEPH RUSZAL		life. DO NOT us		orking		
SEPH RUSZAL		LABORE			BREWERY	
	A		18. Mather's No.	me (First, Middle Maide LA PUPA LA UNKN		
Informant's Name/Relationship (T			(Street and Number or F			Code)
	AUGHTER	221 S. AN	N STREET,			231
Method of Disposition	Removal from State	cemetery, crematory or or	ther place)		Location - City or To	wn, State
□Donation 5 □Other (Specify		. STANISLA			LTIMORE,	
ignature of Funeral Service Licens	3 Min	1901	d Address of Facility & ZEILER EASTERN A	VENUE, BAL.	ERAL HOMI	D. 21231
Part1. Enter the disease, or comp shock, or heart failure. List only o adiate Cause (Final use or condition ting in death)	a. Due to (or as a conse	equatory	Anat	ac or respiratory arrest,		Approximate Interval Between Onset and Death M/ Mde
entially list conditions, , leading to immediate a. Enter Underfying e (Disease or injury nitiated events ling in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)					
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Other significant conditions co	ontributing to death but not re	sulting in the underlying ca	ause given in Part I.	23e. Did tobacci	o use contribute to th	- 4
				24a. Was an autopsy performed?	prior to con death?	psy findings available pletion of cause of 2 No
/as case referred to medical xaminer?	Hospital:	~	Other	eath (Check only one)		
Yes 2 □ No anner of Death	1 Inpatient 2		4 Nursing	Home 5 Residence		')
Natural 5 Pending investigation	(Month, Day Year)	Injury	8c. Injury at Work? 1 □ Yes 2 □ No	200. 2000/150 1104 111	july occurred	
	28e. Place of Injury - At I	home, farm, street, factory		28f. Location (Street City or Town, Sta	and Number or Rura	l Route Number,
Suicide 6 Could not be determined	niner: On the basis of examin	nowledge, death occurred a nation and/or investigation,	at the time, date and place, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
Homicide determined Certifier 1 Certifying Physics	and manner stated.	29c	. License number	29d. [Date signed (Month, I	Day, Year)
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Certifier (Check only one) determined determined	and manner stated.		>447.91		2/1/06	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ugene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign If Under 24 Hrs. (In ws. last birthday) **Funeral** Hours Months Days 2 🗆 E Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 X65 2 No N Director 10g. Citizen of What Country? or iteme 23a Completed by Funeral Race - American Indian Black, White, etg/ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation
Give kind of work done during most of working
life DD NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other than Elementary(Secondary (0-12) (1-4or 5+) To Be and Mental is marked Department of Heelth a Important: if Item 27 is any injury or other trains 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Approximate Interval Between Onset and Death ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by is completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 XUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mea? 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Medical Certification: To 1 Tes 2 X No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after do To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of Wo Street 600

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

2006

			For State Registrar	State of Ma	aryland		rtment o				giene Reg. No.	006	039	38
	Physicia	an	Decedent's Name (First, Middle,	Last)	-	C.	· h			2. Date of Dea Month	Day	Year		of Death
	/Medic	al	4a. Facility Name (If not institution,	give street and number)		7,	4h City To	wn or Loc	cation of Death	rebruc		County of Deal	5	TOTAM
	Examin	er	John Hopkins Box	yo'rew co	0	ter	Ball		S1C		8	alti-	ore C	ity
I	Funeral Director		219–62–1846	5. Sex 1 M 2□ F 7. Ag	e (In yrs. Ia 49	st birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day 2-13	h y, Year) 3–56	9. Birt Co	hplace (State ountry) Md.	e or Foreign
1	ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside	City Limits
1	a-f sh	ctor	Md.	NA		Balti	more						X□Y	es 2□No
1	death with the Maryland ms 23a or 28a-f show Finust be Indiffed at	Director	10e. Street and Number				10f. Zip Co				10g. Citiz	en of What Co	untry?	
-	9ath v	Funeral	1621 N. Caroli	ne Street	Ever in U.S	3. 13. V		1213	anic Origin? (Se	ecify Yes or No-	- 1	USA 4. Race - Ame	nican Indian	
9500	De liled within 72 hours after death with the inadylar lat Hygiene. Ital Hygiene. Ital Hygiene. avent, Ital Medical Exert in retirinative notified at	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?			Yes, specify		Mexican, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit		
ָבְּיבְּיבְּיבְּיבְּיבְיבְּיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְי	natur	Completed	15. Decedent's (Specify only highest			(Give	lent's Usual C	done durir	n ng most of work	ring	16b. Kin	d of Business	Industry	
7	within ene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or	5+)		oo not use i lible	retired)			Cor	nstruct	ion	
ט פ	Hygir other	a	12th grade 17. Father's Name (First, Middle, La	ast)			TIDIE	18	. Mother's Nam	e (First, Middle,			1011	
rylan	permit. Fages 1 and 2 should be Department of Health and Mental important: If item 27 is marked any injury or other traumatic av once.	ToB	Paul 19a. Informant's Name/Relationshi	p (Type, Print)	Smith		a Address (S	Street and	Lilli Number or Rui	e a <i>l Route Numbe</i>	Mae		Jackso Zip Code)	n
<u> </u>	alth ar 127 is er trau		Cynthia Heard	Sist	er		•			, Randa	-			.33
O	of He of He or othe		20a. Method of Disposition 1- Burial 2 ☐ Cremation	B □Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name natory or othe	of er place)		Date		ation - City or		
Saitimo	trag thent rant: njury o		` 4 Donation 5 ☐ Other (Spe	ecify)		ng Mem		A 41 d	2-16			dallsto		
מ	Depariment in point i		21. Signature of Funeral Service Li	w one	<u>ک</u>		arch F		-	llol E		nore, M rth Ave		.202
E	Physician /Medical Examiner purual-transit	Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little fundarlying Cause (Disease or injury that initiated events resulting in death) Last	a	a conseque	ence of):	ler the mode of	of dying, s	CCUAC		clor	~C D	Approximinterval E Onset an 2 d	Between
08/00	meate be executed g physician and as the burial-transit	cal		d.					- 3			-		
O. Box	ne death certificate / the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic preg Other (spec				2	3d. Date of del Month	ivery Day	Year
oras, r.	iaw requires inat the de- as been signed by the a 2 should be detached f	by	Part II. Other significant condition	s contributing to death b	out not resul	iting in the ur	nderlying cau	se given ir	n Part I.		obacco us	se contribute to		of death?
Ē,	sician: The law requir certificate has been s rector, page 2 should	Completed	Hypertensin	on alila	٠	\ 00.						24b. Were au prior to death? 1 ☐ Yes	completion of	as available f cause of
	ysician: is certifical director, p	BeC	25. Was case referred to medical examiner?	10101	JO !!	pada		26	3. Place of Dea	h (Check only o		10,163	20110	
5	this ald	은	1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending	Hospital: Impatie 28a Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury	t 3 DOA 28c	. Injury at Work?		ome 5 Resid			cify)	
DIVISION	Atten ar deat actor: by the	ertification;	2 Accident investigation 3 Suicide 6 Could not determine	ot be 28e. Place of Inj	ury - At hor c. (Specify)	me, farm, str			20110	28f. Location (S City or Tow		i Number or Al	ural Floute N	umber,
	to the hospital or within 24 hours afte To tha Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	of my know f examination	vledge, death ion and/or inv	n occurred at vestigation, in	the time, on my opinion	date and place, on, death occur	and due to the cred at the time,	cause(s) adate and	and manner as place, and due	stated. to the cause	∋(s)
	within To th compi	Me	29b. Signature and title of certifier	150			29c. L	icense nu	umber		29d. Date	signed (Mont	h. Day, Year)
1	O		1 Mis	1	~ <u>~</u>	•	5	700	1383	5	Febr	way	1819	000
3	\		30. Name and address of person we terrifer Forti	scompleted cause of c	death (Item	23a) (Type,	Print)	(ero	circl	red at the time,	pro	ze m	7 913	PE
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3	32 Registr	rar's Signat	иге	we							

			1 - For State Registrar	State of Ma		artment of Health a rtificate of Death		gieņe _{Reg. No.} 006	03939
	Physici		Decedent's Name (First, Middle, Lamont			Smith	2. Date of De Month Febru	Day Ye	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of		4c. County of [
			University Ho	ospital		Baltimore (City	n/a	
	Funeral Director				e (In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bir (Month, Da	ly, Year)	Birthplace (State or Foreign Country) Md.
	land w		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary	ţ	Md. N	i A	Baltim	ore			1 X Yes 2 □ No
	with the	i Direc	10e. Street and Number 1053 W. Fair	mount Avenu	e	10f. Zip Code 21223		10g. Citizen of Wha	t Country?
9036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow lical Exactinational be notified at	t by Funeral Director	11. Marital Status 11. Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? d 1 Tyes 2018 If Yes, Give Year or Dates:	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		14. Race - / Black, V Specify:	American Indian, White, etc. Black
5-0	72 h	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most	t of working	16b. Kind of Busin	ess/Industry
Maryland 21215-0036	I within pene. r than "	Completed	Elementary/Secondary (0-12) 9th grade	College (1-4or 5	i+)	employed	e di Working	NA	
nd	6 E 5 5	Be	17. Father's Name (First, Middle, L	ast)			er's Name (First, Middle,		
Z a	2 2 2 3	7	Lamont		Smith		ura	Johnson	
	s 1 and 2 shou if Health and M Item 27 ie mar other treumet		19a. Informant's Name/Relationshi Shanera Watsor		105	ng Address (Street and Number 3 W. Fairmount			
Baltimore,	ges t of f it		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			sition (Name of natory or other place) Cemetery	Date 2-15-06	20c. Location - City	or Town, State
Balt	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Li	censee (V) au	22	Name and Address of Facility March F.H. Ea	y Ba	altimore, Ol E. Nort	Md. 21202
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	9		er the mode of dying, such as	cardiac or respiratory ai	rrest,	Approximate Interval Between
40	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_ aunshi	a consequence of):	of polvis u			
68760,	ificate be executed g physicien and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):				
387	phys phys the	edical		d				-	
P.O. Box 6		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
	90	d by Pr	Part II. Dther significant condition	s contributing to death bu	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
Vital Records,	ysician: The law rec is certificate has bee director, page 2 shoo	Completed							a autopsy findings available to completion of cause of a? Yes 2 \sum No
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place	of Death Check only o	-	103 22 10
	Physic this ce al dire	2	1 Ves 2 No	Hospital:	nt 2 ER/Outpatien	t 3□ DOA Other: 4□ Nui	rsing Home 5 🗆 Resid	lence 6 Other (S	Specify)
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	ation:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investiga	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	shot
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no determin		rv - At home, farm, stre		28f. Location (S City of Ton	Street and Number of	Rural Route Number, West Lomberds
	To the Hospitel or within 24 hours afte to the Funerel Dir. completely filled in the football of the football	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the best o aminer: On the basis of and manner stat	examination and/or inv	occurred at the time, date and estigation, in my opinion, deat	d place, and due to the o th occurred at the time, o	cause(s) and manner date and place, and	r as stated. due to the cause(s)
	To The County	Ž	29b. Signature and title of certifier		000	29c. License number		29d. Date signed (Ma	onth, Day, Year)
h	2		30-Name and address of person wi	o completed cause of de	HOLL (Item 23a) (Type I	OCME		February	y 8, 2006
4			PATRICIA A	CONICA-F	Bllakme		et Raltimo	re Marvilor	nd 21201
	Star Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	3461		- Junyia	21.071

			1 - State Amend item	State of Ma 18 per fh g	ryland / Dep 855 5-12-	partment of F	lealth and Death		giene Reg. No. 0 0 1	6 03940
	Physici		Decedent's Name (First, Middle, La CEORGE	st) E ROBERT SM	тти			2. Date of Dea Month		3. Time of Death 10:37 P
	/Medic		4a. Facility Name (If not institution, give		<u>T T T T T T T T T T T T T T T T T T T </u>	4b. City, Town, o	r Location of Deat		4c. County of	
		125	NATIONAL NAVAL N	MEDICAL CEN	TER	ВЕТН	ESDA		MON	TGOMERY
	Funeral		,	Sex 7. Age 1M∑M 2□F	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year)	9. Birthplace (State or Foreign Country)
-36	Director		121-46-9253 Usual Residence of Decedent	A	55 JO YIS.			Sept.	9,1955	New York
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man Marien	tor	VA Fairfax		Herndon					1 ☑ Yes 2 □ No
	ith the Marylar or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	death with the Maryland ms 23a or 28a-f show		710 Tamarack Way	#2C		20170			U.S.A.	
		Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 1 X Yes 2 ☐ No		 Was Decedent of F If Yes, specify Cub 	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		- American Indian, White, etc.
3-003p	within 72 hours after death with the Maryla then "natural," or items 23s or 28s 4 show the Moulcel Exemples count by motified at	þ	3 Widowed 4 Divorced	If Yes, Give 1	988 - 998	1 ☐ Yes 2🏋 No	Specify:		Specify:	White
5	72 ho	Completed	15. Decedent's E (Specify only highest gr.	ducation	16a. Dec	edent's Usual Occup ve kind of work done	pation	duna	16b. Kind of Busi	
Ž	d within jiene. ir then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retire	d)	, Ally		
2	lled w Hygier ther th		17. Father's Name (First, Middle, Last	2	Sof	tware Engi		me (First, Middle,	Comput	
and	2 should be filed volume and Mental Hygie is marked other traumatic event, in	Be	Timothy Smith	/				eh Greck	,	
<u> </u>	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship	Type, Print)	19b. Ma	iling Address (Street				tate, Zip Code)
Ž	nd 2 alth ar		Jane Martell (Fiance)		Tamarack V				
ค์	of Hei		20a. Method of Disposition	75		position (Name of ematory or other pla			20c. Location - C	
Ĕ	Page ment c ant: if		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Quantico	National	2/1	1/2006	Triangle	e, Virginia
Бапппо	permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked eny injury or other traumatic evone.		21. Signature of Funeral Service Lice	a Allo	Center	ery 22. Name and Addre	ss of Facility Mo	ountcast1 Blvd. D	e Funera ale City	11 Home 7, VA 22193
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do not e	inter the mode of dyir	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPSI	S					Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
).	Sequentially list conditions, if any, leading to immediate	b. PNEUM	ONTA consequence of):			A.K		
	nsit	Examiner	Cause (Disease or injury		IC BOWEL					
ń	execun and ial-tra	Exal	that initiated events resulting in death) Last	U	consequence of):					
00/00	ificate be executed g physicien and as the burial-transit	edicai	(d						
	E On a	Med	IF FEMALE:							
Š D	w requires that the death certif been signed by the ettending should be detached for use a	ician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death 3	Ectopic pregnancy	/		23d. Date of Month	
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)				
7.	that the ed by th detache	/ Physi	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
cords	requires een sign nould be	d by						1 🗆 Y	es 2 □ No 3	☐ Probably 4 ☐Unknown
ဂ သ	law rec as bee	ompieted						24a. Was a	an 24b. We	ore autopsy findings available or to completion of cause of
r	The la ate ha page 2	шо		3				autops perfor	med? dea	or to completion of cause of ath?]Yes 2□ No
	ien: rtifica ctor, p	Be C	25. Was case referred to medical				26. Place of De	ath (Check only or	**	100 20 10
	Physicien: rthis certific ral director,	To	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 XInpatien	t 2 ER/Outpati	ent 3 DOA Oth	er: 4 Nursing H	lome 5 Resid	ence 6 Other	(Specify)
	ding Physicien: The lav h. After this certificate has funeral director, page 2	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b. Time Injury	Wor		28d. Describe h	ow injury occurred	
DIVISION OF	ttend death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	e One Diese of Injur	ry - At home, farm, s		Yes 2 □ No	29t Location (C	troot and Number	or Rural Route Number,
2	el or Attending F s after death. Il Director: After Id in by the funera	Certification:	4 Homicide determined	building, etc.	(Specify)	street, lactory, office		City or Tow	n, State)	or Aurar Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1X Certifying Pl (Check only one) 2 Medical Exal	nysician: To the best of miner: On the basis of and manner state	examination and/or	ath occurred at the til investigation, in my c	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)
	To the Within To the Comp	Me	29b. Signature and title of certifier	- ()		29c. Licens	e number	2	29d. Date signed (Month, Day, Year)
	a		Hundsay	& Jone	2, MD	0101	236795 (VA)	27 JA1	N 2006
4	4		30. Name and address of person who			e, Print)		NAL NAVAL		
	S\$5		LINDSAY E. JONES		SN de Signaturo		BETHES	SDA MD 20	889-5600)
	Sta		31. Date filed (Month, Day, Year)	32 Registra	s Signature					

DHMH 17 Rev 1/2001

ORIGINAL

				- 10000	State of Maryla		ent of Health and N	-	_	
				1 - For State Registrar	olato ol maryto	-	ate of Death	Reg.	711116	03941
	B. 6			1. Decedent's Name (First, Middle, Las	(1)		, ,	2. Date of Death		3. Time of Death
4		hysici: /Medic		ANTOINET	re	SAI	utoni		Day Year 1, 2006	0157 M
		xamin		4a. Facility Name (If not institution, give			ity, Town, or Location of Death		4c. County of Deat	
	<u> </u>			5. Social Security Number 6. S		Y - C . s. last birthday) If Un	der 1 Year If Under 24 Hrs.	R Date of Birth		FORD
		ineral rector			M 2/K F	83 Yrs. Month		8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign puntry) Apy / PW >
		*		Usual Residence of Decedent				1-(Mg 17	1104 1	(ANGII:W)
	arylar	ehow d at	_	10a. State 10b. County		City, Town or Location	162-1			10d. Inside City Limits
	1215-0036 within 72 hours atter death with the Maryland ene.	s or 28a-f ehow be notified at	Funeral Director	MARYLAND HARI	org		NGDON	10-	0.5.	1 Yes 2 No
	with	l be		10e. Street and Number 20 BOXHILL	South.	Phys. 10t.	Zip Code 21009	10g.	Citizen of What Co	
1	death	ma 2	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was De	cedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race · Ame	nican Indian,
V	eafter .	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		specify Cuban, Mexican, Puerto s=2 X No — <i>Specify:</i>	Rican, etc.)	Black, White	e, etc.
$\overline{\bigcirc}$	5-003	LEXE	d by	3X Widowed 4 □ Divorced	Year or Dates:				Specify: U	Unite
	15-	nat redict	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of work	ing 16t	b. Kind of Business/	/Industry
	2121 Id within giene.	T The	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		Clerk	5	ANTONI	S MARKET
	عَ اللَّهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ عَلَيْهُ	othe Vent,	BeC	17. Father's Name (First, Middle, Last)	4			e (First, Middle, Mail	den Sumame)	
	ylai Nenta	s marked umatic e	10	VINCENT	HMON			INC	Del	ANEY
2	Mary d 2 shou	raum Taum		19a. Informant's Name/Relationship (7	1	19b. Mailing Addr	ess (Street and Number or Run	12 1 1	1 /	- //- /
0	e, P	em 27 ther t		DINO ITMONICA 20a. Method of Disposition	- Nephew	76 28 K			45 VEGAS Location - City or	
3	ages ant of	t: if it		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crematory	or other place)			
L	Baltim permit. Pag Department	Important: eny injury pnce.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				5,2006 UI	4/1/1010	MARYIAND
7	Balt permit. Departr	d y o		> Pharles	ann	Jos	and Address of Facility ANA S CONICIII	UNO JR	3Alto.19	D2127.4
				23a. Part1. Enter the div ase, ir comp shock, or heart failure. I st only	olications that caused the de	ath. Do not enter the m	node of dying, such as cardiac	respiratory arrest.		Approximate Intervat Between
4	Phys	ician		Immediate Cause (Final disease or condition	· Acuto	Remal	Filleral			Onset and Death
		dical niner		resulting in death)	Due to (or as a cons	equence of):	F 10.00			1000
7	LAUI		_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	I've Heaut	nulux			
58	petr	nsit	Examiner	Cause (Disease or injury	220 10 (0) 23 2 00113	squaree or).				
178	760, te be executed	sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):				
Sign	-	<u>~</u> 00	cai		d					
3	I Records, P.O. Box 68 The law requires that the death certifica	attending ph	by Physician/Med	IF FEMALE:						
2)	Box	for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tal death 3 Ectopic	pregnancy		23d. Date of del Month	ivery Day Year
- 1	P.O.	n hed	iysic	1 Yes 21 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 Other	(specify)			,
6.0	s that	ned by e detac	y Ph	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
0	Records,	should be		Lympheden	ra, Venon	s Strellis	>, coumany	1 ☐ Yes	20 No 3 □ Pr	obably 4 Unknown
2	PCO law re	2 5	Completed	artery Dise	are.			24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	<u>د</u> ۽		Com					performed	death?	2 □ No
	Vital	director, pag	Be	25. Was case referred to medical examiner?	Hannitali /			h Check only one		
2	Phys of	5 D	<u>۲</u>	1 Yes 2 No		ER/Outpatient 3 28b. Time of		me 5 Residence		city)
anto		funeral	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work?	28d. Describe how i	njary occurred	
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	To the Hospital within 24 hours	ely ill	edical	(Check only 2 Medical Exan	ysicien: To the best of my ki	nowledge, death occurrenation andor investigati	ed at the time, date and place, ion, in my opinion, death occuri	and due to the caus	e(s) and manner as	s stated.
	the thin 2	completely	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		Date signed (Monti	
1	P M	- 8		De la comina		D0	H 0/ / 2 2/	290.) II, I a -	, Jay, real)
	10	1	ì	30. Name and address of person who o	completed cause of death (Iti	em 23a) (Type, Print)	11 000 640	TOM M.D.	111/200	00.
	U	,		UCMC 500	upper (Lusanoa	Ke Drive	BUAN	- mo:	21012/
		Sta legistra		31. Date filed (Month, Day, Year) FFB 1 3 2	32. Figistrar's Sig	nature				1
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Amend item#10b-c,perfH,G352,2/13/00 The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Eusenia Tors Februar 72606 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** altimore Jecours 6 304 Baltimor 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral -84-13 Months Days Hours Min. 1 ☐ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic average. 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location N/A Baltimore 1 XYes 2 □ No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE UNEMPLOYED - NEVER WORKED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDDIE ARVELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLARD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) V CEMETERY 102-14-06 Name and Address Facility 21. Signature of Funeral Service Licensee FULTON AVE. BALTO, MD.2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 ک ،کم /Medical Due to (or as a consequence of) Examiner Embolism IMODA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of). the ettending physicien and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Box 68760. After this certificate has been signed by the ettending physican director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 000 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death Check only one No Hospital: Certification: To 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident М 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title at 29c. License number 00053850 of person who completed cause of death (Item 23a) (Type, Print) 2000, W BALTIMORE ST, BALTIMORE MO CHWART V 31. Date filed (Month, Day, Year) FEB 1 3

DHMH 17 Rev 1/2001

State

Registrar

2006

Urban, Yoseph

Division of Vital Records, P.O. Box 68760,

Physician (Michical Examiner 1. Family Name (if not restitute, give streat and number) 1. Family Name (if not restitute, give streat and number) 1. Special Physician (Not restitute, g	COLUMN TO		1 - State Registrar		Ce	rtificate of	Death	Reg.	No.	03943
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Social Social			4a. Facility Name (II not institution, give	street and number)		-	r Location of Death		4c. County of Dea	ath
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Immediate Cause (Final disease or condition resulting in death) Part Description	Depart Import eny in		21. Signature of Funeral Service Licens	99	22	Charles L	Stenvens F	uneral Home Itimore MD	Inc. 21230	
The past IZ and the past IZ an	/Medical examiner	ш	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ACUTE Due to (or as a Conge Due to (or as a	RLOGI consequence of): Light consequence of):	Failur	L			Onset and Death
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1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 5 Pending investigation 7 State 1 Described Number, At home, farm, street, factory, office 28s. Place of Injury At home, farm, street, factory, office 28s. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	s certif directo	Ω	examiner?	lospital:	2 □ ER/Outpation	t 3 DOA Oth			s C Dother (Co.	
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2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Dir		4 Homicide determined	building, etc.	(Specify)			City or Town, S.	tate)	
29c. License number 29d. Date signed (Month, Day, Year) February 5, 200 6	4 F 9		(Check only Z Medical Exami	ier. On the basis of e	xamination and/or in	n occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [| - State Registrar Amend Item #10e&19b PEr Ana Edition of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 7:00 PM M 2006 February 6, George Von Hagel Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Social Security Number **Funeral** 1 € M 2 □ F Apr 6, 1931 Director 74 Maryland 218-26-9890 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Hampstead MD Carroll 10e. Street and Number 3830 10g. Citizen of What Country? 10f. Zip Code 21074 USA Normandy Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes 2√2No Specify: white <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Alena Udes George Von Hagel Sr 19th offeiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3820 Normandy Drive Hampstead, MD Kathryn Von Hagel/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Strates Licensee Roan Id S. Wade, Director State Anatomy Board 655 W. Baltimore Street encey alle 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestir **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed dement Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f Division of Vital Records, P.O. 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Hostminster mn 21157 349 m. PANSURIYA malcolm

State Registrar

DHMH 17 Rev 1/2001

FEB 1 3 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend item#21b, period Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MARLES 9 15 PM 02 08 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Paus | Hours | Min. | Month, Day, VINDAL NURSING HOME NIA 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) 1 M 2 F -20-398 MAR Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MARYLAND 10e. Street and Number 10g Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Nes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify. 3 X Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDERAL 12 HI GRADE EDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OHN HENR WOOD 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON DWARP WOOD ORDELIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST OWINGS MILLS 21. Signal re of Fineral Service Licensee 22. Name and Address of Facility JR, FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Porkinsons End stage
Due to (or as a consequence of): colonary auto DISCOSC Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 21/2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident

Priysician /Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760 ρ P.0. the Division of Vital Records, certificate To the Hospital or Attending Physician: director After death. after death Director: / within 24 hours a To tha Funarel I

Examiner Physician/Medical Completed by Be P Certification:

3 ☐ Suicide

29a. Certifier

4 Homicide

Physician

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 is marked othar I

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Baltimore, Maryland 21215-0036

Director

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1 Decritying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

6 Could not be determined

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00063174

02/08/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 Belvedere AVE BALTIMORE, MD 21215 31. Date filed (Month, Day, Year)

State Registrar

3

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Lola Wheeler 06-00833 CT

	Type of Print in black indelible ink. Ensure A				
	State of Maryland / Department of Health and N	lental Hy	giene	ns	0391
e istrer	Certificate of Death		Reg. No.	UU	UUJA
ent's Name (First, Middle, Las.		2. Date of Dea			3. Time of De
ola Wheeler		Month	Day	Year	

Physiciar /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 271s marked other then "natural", or Items 23s or 28s-1 show any injury or other treumatic event, the Moulcal Examinar marker nothing at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificete hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	. Decedent's Name (First,	, Middle, La	ast)							2. Date of D	aath			3. Time of D	eath
ı	Lola Whee									Month	Day		Year		
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						40 . Cl							,, Dodui		
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1	23a. Part 1. Enter the disease shork, or heart failure	ase, or com	plications that	caused the	death. Do n	ot enter the m	node of dyll	ng, such as	cardiac	or respiratory	rrest.			Approximate	
l,	snork, or neart failure Immediate Cause (Final	e. List only	one cause an e											Interest Detroit	
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Registrar

	1 - For State Ragistrar	State of Maryland / Dep	partment of Health and I ertificate of Death	•	e 2006 0301
Physician /Medical Examiner	Decedent's Name (First, Middle, La. 4a. Facility Name (If not institution, giv.	ROBERT FRANCIS	WELSH, JR. 4b. City, Town, or Location of Deatl	FEB. 8, 2	3. Time of Death 2006 9:30 A
Funeral Director	199 E. NICODEM 5. Social Security Number 216-16-8288 Usuel Residence of Decedent		WESTMINSTER // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Carroll 9. Birthplace (State or Foreign Country) MARYLAND
he Maryland 28a-f show pillied at	MD 10b. County CARROL	L 10c. City, Town or WESTMI	NSTER		10d. Inside City Limits 1 ☐ Yes 2 🙀 No
3a or 2	10e. Street and Number 199 E. NICODE	EMUS RD.	10f. Zip Code 21157	10g. C	itizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mantal Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
ed within 72 houygiene. The Medical Et. The Medical Et.	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	Jucation de completed) College (1-4or 5+) 16a. Dec (Given life)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) OWNER		CAVATING CO.
Mental Hyg Mental Hyg Larked other Latic event, I	17. Father's Name (First, Middle, Last) ROB	ERT FRANCIS WELS	H, SR. ALICE	ne (First, Middle, Maide E GUSTAF	n Sumame)
Tang z sin	19a. Informant's Name/Relationship (194) MARY E. WELSH 20a. Method of Disposition	- WIFE 199		.,WESTMIN	ISTER, MD. 21157
rtment of strant: if its	1 Survive of 1 Service Licer	DEER PAR	vosition (Name of amatory or other place) K CEMETERY 2/13	3/06 SMA	ALLWOOD, MD.
od w			22 . Name and Address of Facility ${ m FI}$		
ate be executed hysicien and hysicien and the burial-transit the burial-transit alical Examiner	Immediate Cause (Final disease or condition resulting in death)	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	UCES PUMONARY		Approximate Interval Between Onset and Death Minima
signed by the attending ph d be detached for use as th i by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
been signed b should be deta	PARCXYSMAI ATE			23e. Did tobacco	use contribute to the cause of death?
icate has been signed by the attending of a page 2 should be detached for use as it Completed by Physician/Med		CED HYPERGLYCEMIA	<u>t</u>	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Physician: this certificaral director, i	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th (Check only one) ome 5∑ Residence	S (20th-1/2)
After fune	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	
Hospitel or Attending 4 hours after death, Funerei Director: Attentiel filled in by the funer Ilcal Certification	4 Homicide determined 29a. Certifier Certifying Ph	building, etc. (Specify)		City or Town, State	9)
To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier	/sician: To the best of my knowledge, dea iner: On the basis of examination and/or in and manner stated.	29c. License number	29d. Da	te signed (Month, Day, Year)
1	30. Name and address of person who d	completed cause of death (Item 23a) (Type		inster, ma	109/2006
0	I HOWASK. GAG	VIN'IL 291 STUNE	L AVENUE WESTM	interest of a	21157

Registrar

			1 - For State Registrar	State of Ma	aryland /	Depa <i>Cei</i>	artment of rtificate of	Health a	and M		jiene leg. No.	006	03949
*	Physici /Medio		Decedent's Name (First, Middle, CHARLENE	G.		ALL]	EN			2. Date of Dea		2006	3. Time of Death 7:49 A M
	Examir		4a. Facility Name (If not institution, PRINCE GEOR	give street and number) GE'S HOSPIT	AL		4b. City, Town, CHEVE		of Death		PR	ounty of Death	EORGE'S
	Funeral Director		5. Social Security Number 578-56-8322 Usual Residence of Decedent	5. Sex 7. Ag	e (In yrs. last bi 63	Yrs.	If Under 1 Yea Months Day		Min	8. Date of Birth (Month, Day OCTOBER	21 1	Co	hplace (State or Foreign untry) 'ASHINGTON, DO
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "naturel; or items 23a or 28e-f show other traumatic event, the Mudical Examinar must be notified at	by Funeral Director	10a. State 10b. County MD PRINCE 10e. Street and Number 5919 APPLEGARTH			TOL	HEIGHTS 10f. Zip Code 20743				U.S	en of What Co	
0036	hours after de urei', or items al Examiner r		11. Marital Status t □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	No		Was Decedent of f Yes, specify Cu	ban, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	S		a, etc. ACK
Maryland 21215-0036	filed within 72 Hygiene. other then "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, L.	grade completed) College (1-4or 5	i+)	(Give life. l	dent's Usual Occ kind of work don DO NOT use retii	e during mos ed) NURSE			GOVI	e of Business/l	•
ylanc	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	To Be	CHARLES PRINCE					SARA		e (First, Middle, CUTHBERT		umame)	
	1 and 2 sh Health and iam 27 is m		19a. Informant's Name/Relationshi				ng Address (Stree				-	Town, State, 2 20019	lip Code)
Baltimore,	permit. Pages 1 a Department of Her Importent: if Itam eny injury or othe		20a. Method of Disposition 1 🖾 Burial 2 🗀 Cremation 3 4 🗀 Donation 5 🗀 Other (Special Control Co		cemete	ary, cren	sition (Name of natory or other pi		1/28,	06 j		VER, MA	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service L	\gg		7	Name and Add	OVER	ROAD	B. JENK LANDOVE	CINS ER, M	FUNERA:	L HOME
8760,	Physicien and ph	dicai Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	AL CARD	Of): BRE	ARRHYTHI	MIA	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
.O. Box 6	The law requires thet the death certific tie has been signed by the attending p page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnan Other (specify)	су			23	d. Date of deli	very Day Year
₽.	w requires thet i been signed by should be deta	by	Part II. Other significant condition HYPERTENSION	s contributing to death bu	ut not resulting i	in the ur	nderlying cause g	iven in Part I					the cause of death?
Division of Vital Records,	ilcian: The law r certificate has be rector, page 2 sh	Completed	STEROID INDU	CED DIABETES	S						ned?	24b. Were aut prior to c death? 1 ☐ Yes	topsy findings available completion of cause of
=	Physician: this certificaral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:	nt 2 🕅 FB/O	utnatien	t 3 DOA O			n <i>Check only on</i> me 5 ☐ Reside	-	Other (Spec	264
sion of	D 00		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injur (Month, Day		Time of Injury	28c. Inj	ury at ork?		28d. Describe ho			ay)
DIX	tel or Attendir s after death. el Director: Af ed in by the fur	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, fa c. (Specify)	arm, stre	eet, factory, office)		28f. Location (Si City or Town	reet and I n, State)	Number or Ru	ral Route Number,
	he Mospitei or in 24 hours affe he Funeral Dir pletely filled in i	edicai	29a. Certifier 1 D Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	examination ar	e, death	occurred at the restigation, in my	time, date an opinion, dea	d place, th occurr	and due to the coed at the time, d	ause(s) ar ate and p	nd manner as ace, and due	stated. to the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier J. Wendel	em Come	le ms		29c. Licer	137	16	2	9d. Date :	signed (Month	Day, Year)
2			30. Name and address of person w				,	NE LAF	RGO,	MARYLAN	D 20)774	
10 mg	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 7 20	Registra	ar's Signature	for	de						

		= State Registrar Amend #13. 1. Decedent's Name (First, Middle,	Per FH PGC 1—27- Last)	-06 cr C	ertificate o	T Death	2. Date of D		Jb I	3 9 5 0 3. Time of Death
hysicia	an	Floribell E. A					Month 01	21	96ar	6:15A M
Medic xamin		4a. Facility Name (If not institution,			4b. City, Town	, or Location of De	ath	4c. Cour	nty of Death	
Xallilli	eı	Doctors Communi			Lanh	am		Princ	ce Geo	rges
eral ctor		5. Social Security Number 626-22-2818	*	(In yrs. last birthda 85 Yrs.	y) If Under 1 Yea Months Day		8. Date of Bi (Month, D 09 1	irth lay, Ye <i>ar)</i> 3 20	9. Birthp Gour Cuba	place (State or Foreign htry)
TO THE PERSON NAMED IN		Usual Residence of Decedent 10a. State 10b. County MD Prince	Georges	10c. City, Town or					1	0d. Inside City Limits 1 Y Yes 2 □ No
	rect	10e. Street and Number	Georges	<u> </u>	10f. Zip Code)		10g. Citizen o	of What Cour	ntry?
27.12	O E	6709 Lamont Dri	ve		20706			U	SA	
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 50	ver in U.S. 13	B. Was Decedent of If Yes, specify C		(Specify Yes or N lerto Rican, etc.) Luban	В	lace - Americ lack, White, c ^{ify:} Blac	etc.
	eted b	15. Decedent's (Specify only highest	Year or Dates: Education grade completed)	16a. Dec	edent's Usual Occ re kind of work doi . DO NOT use ret	cupation ne during most of	working	16b. Kind of		
	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) (+	J rsing As			HOsp	ital	
	Be	17. Father's Name (First, Middle, La	est)				Name (First, Middle	e, Maiden Sum	ame)	
	2	Ernesto Allen 19a. Informant's Name/Relationshi	(Tyge Print)	19b. Ma	iling Address (Stre		ia Mills Rural Route Numi	ber, City or Tow	vn, State, Zip	Code)
er traumatic event, <u>ibe Mac</u>		Richard Rae/Son								
y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of		│ The Eve	rgreen C	em. 1_	anham, M	Brook.	Lyn. N	.Y.
any injury or other traumatic once.		21. Signature of Funeral Service Li			22. Name and Add 4217 9th	dress of Facility	MArshall' W. Washir	s Funer	ral Ho D.C. 2	me 0011
as the burial-transit	ledicai Examiner	23a. Part1. Enter the disease, or control of heart failure. List of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Conges Due to (or as a b. Due to (or as a c.	tive Hear a consequence of): a consequence of): a consequence of):						Interval Between Onset and Death
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2	d by P	Part II. Other significant condition Myocardia	s contributing to death bu 1 Infarction		underlying cause	given in Part I.		I tobacco use co] Yes 2 □ No		he cause of death?
₹ I	Completed						per	s an 24 opsy formed? 2 \(\overline{\Omega}\) No	b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
oage 2	0	25. Was case referred to medical	Hospital:	-		Other	Death (Check only			
oage 2	Be	examiner?	1 Toophus.		BILL SELDOA	4 🗀 IVUI 511	28d. Describe	sidence 6 00 how injury occ		fy)
funeral director, page 2	To Be	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injun	/	Nork! ☐Yes 2☐No				
funeral director, page 2	To Be	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injur (Month, Day	ıry - At home, farm,	M 1	Yes 2 No		(Street and Nu own, State)	mber or Rur	al Route Number,
ely filled in by the funeral director, page 2	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Could no determin	28a. Date of Injur (Month, Da)	ory - At home, farm, c. (Specify) of my knowledge, de examination and/or	M 1 street, factory, office at the occurred at the	Yes 2 No	City or To	own, State) e cause(s) and	manner as s	stated.
iuneral director, page z	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Check only 29a. Certifier (Check only 2 Medical E	28a. Date of Injur (Month, Da) t be ed 28e. Place of Inju building, etc Physician: To the best of comminar: On the basis of	ory - At home, farm, c. (Specify) of my knowledge, de examination and/or	M 1 street, factory, offi ath occurred at the investigation, in m	Yes 2 No	City or To	own, State) e cause(s) and	manner as s	stated. to the cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

ORIGINAL

			1- For State of Maryland / I	Department of I	Health and M	Mental Hygi	•	03952
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	/Medic		Ethel Mae Bailey			Month 01	24 2006	
}	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, C	or Location of Death		4c. County of Deat	George's
	Funeral		500N Harry Truman Dr #106 5. Social Security Number 6. Sex 7. Age (In yrs. last bit			8. Date of Birth		
	Director		10 A 2 7 10 M 20 7 E	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 05/12/	26 Sou	hplace <i>(State or Foreig</i> n <i>untry)</i> uth Carolin
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or l protice				
	Aaryla f sho	ō	Md Prince George"s Lar					10d. Inside City Limits 12 Yes 2 No
	28a-	Funeral Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	
	h with	ai Di	500N Harry Truman Dr #106	207	74		USA	
	ems a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I		ecify Yes or No-	14. Race - Ame	
36	s afte , or It	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ ★o	1 ☐ Yes 2 ☐ No		7 110411, 010.7	Black, White	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a.	. Decedent's Usual Occur	nation	44	.01	ack
75	nin 72 in "ne Medic	plet	(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retire	during most of work ad)	ing	6b. Kind of Business/	naustry
2	d with	Com	Elementary/Secondary (0-12) College (1-4or 5+) 8 th	Nurse Aid	l		Governme	ent
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	aiden Sumame)	
Z	i Men i Men narke netic	70	Luke Fisher		Bell			
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.			Mailing Address (Street				
ē,	tem 2			5700 Brook f Disposition (Name of ry, crematory or other pla			Criase, (v	
<u>o</u> E	Pages ent of ht: If i			ry, crematory or other pla mony Memoj				,Maryland
Baltimore, Maryland	mit. I partm porte. Vinju		21. Signature of Funeral Service Licensee					on Service
<u> </u>	permi Depar Impo any ir		Fory Some	5732 G	eorgia <i>l</i>	Ave Nw W	ashingto	on, DC 20011
,09/	The law requires that the death certificate be executed Was been signed by the attending physician and and angle 2 should be detached for use as the burial-transit	icai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. Due to (or as a consequence of the cause. Due to (or as a consequence of the cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cause. Due to (or as a consequence of the cause. Due to (or as a consequence of the cause. Due to (or as a consequence of the cause of the	of):	0 N			Interval Between Onset and Death
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	res that signed b be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
īd	w require been sig should b	leted b				1 ☐ Yes	2 1 No 3 □ Pro	bably 4 Unknown
al Records,		Complet				24a. Was an autopsy performe	d? prior to c	opsy findings available ompletion of cause of
Vital	Phyelclen: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Ott		n (Check only one)		
Division of	To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, i	n: To	27. Manner of Death 28a. Date of Injury 28b. T	tpatient 3 DOA	4 □ Nursing Hory at	me 5 Pesideno 28d. Describe how	ee 6 □Other (Specinjury occurred	ify)
000	utending f death. ctor: After y the funer	atio	2 Accident investigation		Yes 2□No			
Š	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	rai Route Number,
۵,	pltel		29a. Certifier Certifying Physician: To the best of my knowledge	doob coursed at the st			(-)	
	e Hos 24 h e Fun letely	edicai	29a. Certifier (Check only one) One) Check only one) (Check only one) 2 ☐ Medical Examiner: On the basis of examination and and manner stated.	dor investigation, in my o	me, date and place, ppinion, death occur	ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	29c. Licens			. Date signed (Month	Day, Year)
	5		Herry C. Xa. In	11 03	9550		1-26-	06
			30. Name and address of person who completed sause of death (Item 23a) (CPC) 35 C H a J CV J M D. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	Type, Print) 4850 Fo	bes Blow	Cenhan	, md z	106
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Aprile				

			1 - For State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artmen rtificate			and Me	-	giene Reg. No	HUb	039	53
П	Physici	an	1. Decedent's Name (First, Middle, La							2	2. Date of De Month	ath Da	y Year	3. Time of	
	/Media	cal	Josephine T. 4a. Facility Name (If not institution, given				4h City	Tours or	Location o		anuar		1,2006 County of Deat	4:00	ам
	Examir	ier			nnoer)		Clin		Location	i Uealli			G	n	
	Funeral Director		578-50-2533	eview Sex I□M 2XIF	7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	B. Date of Bir (Month, Da	th y, Year)	9. Birt	hplace (State o	or Foreign
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or L	ocation							10d. Inside C	ity Limits
	Mary I sh	to	Md PG		Ca	amp Spi	rings	;						1 ¬Yes	2 🗆 No
	or 28g	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	untry?	
	ath w	rai	7205 Warwick D				207					USĄ			
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "neturel", or items 23a or 28a-1 show injury or other treumatic event, the Medical Examble Lust be invitted at a.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced	Armed F	2 XNo ive		Was Deced If Yes, spec	ify Cuba	n, Mexican	gin? (Speci , Puerto Ri	ify Yes or No ican, etc.)	-	14. Race - Ame Black, White Specify: B1	e, etc.	
21215-0036	72 hou		15. Decedent's E (Specify only highest gra)	16a. Dece	dent's Usua kind of wor	d Occupa	ition	of working		16b. K	ind of Business/	Industry	
21	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired	uring most)	or working	,	Fed	Govt		
72	e filed within al Hygiene. I other than vent, the Me		17. Father's Name (First, Middle, Last	yrs '	<u> </u>	Secre	etary		18 Mothe	r'e Name /	First, Middle,		Acct	Office	}
au	d be lental	To Be	Joseph Thompso								ollive		osmanio)		
Maryland	2 should be and Mental Is marked reumatic ev	1	19a. Informant's Name/Relationship (19b. Maili	ng Address	(Street a					or Town, State, Z	Tip Code)	
	and 2 salth a n 27 Is	1	Kenneth Bryant	(Son)		11903	3 Ate	n S	tree	t Ft	. Was	h.	Md.207	44	
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	State	 Place of Disposers, createry, createry 	osition (Nam matory or ot	ne of ther place	9)	Dat	te	20c. Lo	ocation - City or	Town, State	
Ë	permit. Page Department of Importent: If any injury or pnce.		` 4 ☐ Donation 5 ☐ Other (Special	y)	Wa	shingt				1-26	-06	Sui	tland	Md.	
Ba	permit. I Departm Importer any inju		21. Signature of Funeral Service Licer	ell &) p~	ТУ		J.	Youi	ng 7			dy St.		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. en	caused the deeach line.	lage 1	mul	Hij	le le	Scl	espiratory and	rrest,		Approximat Interval Bet Onset and I	ween
	Examiner				Hu	De Lo	100	6						100	<u></u>
o,	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a cons	equence of):	67								d
68760,	ficate be physici s the bu	dical	· ·	d											
P.O. Box (The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown		birth 2 □F nant at time o	etal death 3	⊒Ectopic pre ☑ Other (spe						23d. Date of deli Month		Year
	quires Ihat i n signed by uld be deta	by	Part II. Other significant conditions of	contributing to a	leath but not r	resulting in the u	nderlying ca	use give	n in Part I.			obacco u Yes 2	use contribute to	the cause of d	
Vital Records,	The law recate has bee page 2 sho	Completed			-						24a. Was autor perio 1 Yes	rmeg?	prior to death?	topsy findings a completion of co	available ause of
Vita	Physicien: this certificaral director, [Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death (Check only o	ne)			
Division of	To the Hospital or Attending Physicien: The law within 24 buous after death. To the Funerel Director After this certificate has to the Funerel Director. After this certificate has completely filled in by the funeral director, page 2.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		ER/Outpatier 28b. Time o Injury	_	Bc. Injury Work	at	280	5 ☐ Resid d. Describe h		6 □Other (Spec y occurred	sily)	
Divis	tal or Atter s after dea al Director ad in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	259. Flaut	of Injury - Aling, etc. (Spe	t home, farm, str ocify)	eet, factory,	, office		281	f. Location (S City or Tox		d Number or Ru)	ral Route Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the b	e best of my ke easis of exami ener stated.	knowledge, deat ination and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	l place, and h occurred	d due to the at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	1	-		29c.	License	number			29d. Dat	e signed (Month	, Day, Year)	
^	80		1x2v	12			12)-ZI	153	5		6	1,240	56	
L			30. Name and address of person who	completed caus	se of death (I	tem 23a) (Type,	Print)						*		
			Laxmi Berwa, MD 31. Date filed (Month, Day, Year)	7700	Old Registrar's Sig	Branch	Ave	nue	Cli	iton,	MD.	207	3-5		
	Sta Registr		IAN 2 7 200		د معد	K do	R.			•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** a Marie R. Beauvil 22 2006 9:02 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Montgomery Holy Cross Hospital
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 ☐ M 2**)** F Director 579-88-5998 Oct 01,1921 Haiti Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Director 1 Yes 2 □ No Md PG Beltsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a 3112 Ellicott Road 20705 USA Funera 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes Give X 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "ne eny Injury or other treumatic event, the Mental page. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvie Barron Pierre Vilain 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Dolet (Daughter) 3112 Ellicott Road Beltville, Md 20705 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State George Wash Ceme Adelphi Maryland 01-28-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wash DC m Tyrone J. Young 719 Kennedy St. NW 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Adenocarcinoma of Ampula of Vator Weeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cholestaris Weeks Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed c Pancreatitis Weeks burial-Due to (or as a consequence of) attending physician for use as the buria Physician/Medical aElectrolyte imbalance IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2XNo signed by the a Ó 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Munknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Wasan page 2 s 1 Yes 2₺ No 25 No of Vital Be 25. Was case referred to medical examiner? director 26. Place of Death Check only one Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division After Hospital or Attending 5 Pending Injury 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D50987 mp +· Nawa2 3 ame and address of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg Po Box 83819 NAWAZ AHMED 31. Date filed (Month, Day, Year) State JAN 2 7 2006 Registrar

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			Decedent's Name (First, Middle, Last)							2. Date of Deat	1	000	3. Time of Death
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Bal	Depa Impo eny I		21. Signature of Funeral Service License	• (()						B. JENKI			
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)			Kandew L.	Willer		2	000	619:	37		1/25	5/0Cm	
2	(5)		30. Name and address of person who con CANDACE L. WILL	npleted cause of death (Item	23a) (Type, F	Drint)				SILVER	SPR	INE N	1D 20910
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signa					/				

Irani D. Butler 06-0468 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Irani Butler 2006 January 19, 8:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**x** M 2□ F 577-78-2811 47 Yrs. Director May 19, 1958 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f ehow the Madical Examiner must be notified at 10d. Inside City Limits DC Washington 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 USA 512 Ingraham Street NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ol Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Construction Worker llth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental ant: if Item 27 is marked o Henry Butler Catherine Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Ingraham St. NE Washington, DC 20011 Catherine Butler/ Mother or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Riverdale Crematory Jan. 25, 2006 Riverdale, MD 21. Signature of Fun-ral Service Licensee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part - Enter the disease of complications that caused the poets. For not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read a failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AT HEMOSCIENOTH CANDICVASCILLAR DISTAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physicien and s the burial-fransit Due to (or as a consequence of): Box 68760, by Physician/Medicai use as affending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time ol death signed by the a 5 Other (specify) o 9 Unknown 9 Unknown ئ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown been si Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificete 1 Yes of Vital 2 🗆 No To the Hospital or Attending Physician: within 24 hours etter death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 X es 2 □ No 2 XER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Complete: The time is a state of the caus 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yrill Mente January 21, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARITA 111 Penn Street, Baltimore, Maryland D. KORELI 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 7 2006 Registrar

Darrell Buck O6-00844 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpent item#23a,2/,pent 1,852,2/14/06 11

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permit. Pages 1 as Dapartment of Hea Important: if item any injury or othe		1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Trinits	orematory or other place) Feb. 8, Memorial Gardens	2006	Waldorf, Maryland
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Dapa Impo Impo eny i		math	M00668	22. Name and Address of Facility Williams Funeral H	Home, P.A.	Jood Md 20640
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the death y the atter	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Yea
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To the To the Comp	Σ	29b. Signature and title of certifier	11 - 0	29c. License number	29d.	Date signed (Month, Day, Year)
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· /		30. Name and address of person who c	ompleted cause of death (Item 23a) (Ty			
DB 10		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty		et Baltin	nore, Maryland 212

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year JOHN FRANKLIN BURROUGHS y 2,2006 4c. County of Death February /Medical 0400 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Easton

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Month Day <u>Memorial</u> Hospita1 Talbot 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1 XM 2 F Months Days Hours Director 84 Yrs DECEMBER 11 1921 WASH. D.C. 213-16-1349 Usual Residence of Decedent with the Manyland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo MD TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 24375 WIDGEON PLACE #4 238 21663 USA death Funeral Itama 12. Was Decedent Ever in U.S. Armed Forces? Franklin Burroughs re, Maryland 21215-0036 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married Married 6 1 ☐ Yes 2 XNo Specify: ۵ WHITE Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 0 OWNER/OPERATOR AUTOMOBILE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental JOHN F. BURROUGHS ENDIE A. (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 Is any injury or other trau once. NANCY L. BURROUGHS/WIFE 24375 WIDGEON PLACE #4, ST. MICHAELS, MD 21663 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 2/3/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee PACE Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 CF.S.P. Joseph M. Ostrowski. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician onge /Medical Due to or as a consequence of): Examiner eura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due 16 (or as a The law requires that the death certificate be executed burial-transit pulmonacu Box 68760. Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery igned by the atte 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Shknown 0m0 peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 24K No. To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2- No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1@Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 140 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be determined Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059762 Den 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haider SONOS, MO 31. Date filed (Month, Day, Year) egistrar's Signature State 2006 Registrar

			1 - For State Registrar		Maryland / Depa		Health and	d Mental Hy	Reg. No.	06	03959
	Physici		Decedent's Name (First, Middle, William Jenning		r			2. Date of Dea Month JANUAR		2006	3. Time of Death 6:50A . M
	/Medio Examin		4a. Facility Name (If not institution,	give street and numb	per)	4b. City, Town	, or Location of De	eath	4c. Co	ounty of Death	<u></u>
1	LXattiii	-	VA MARYLAND HEA	ALTH CARE	SYSTEM		PERRY I	POINT		CEC	CIL
	Funeral Director		5. Social Security Number 072-07-8155	5. Sex 1 (X)M 2 □ F	Age (In yrs. last birthday) 96 Yrs.	If Under 1 Yea Months Day		fin. 8. Date of Birt (Month, Da)	v, Year)	9. Birthp Coun New	lace (State or Foreign try) York
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion				1	0d. Inside City Limits
	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Modical Exam her must be rediffed at	tor	Maryland Cecil		North Eas						1 XYes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zîp Code)		10g. Citize	n of What Coun	itry?
	h with	a D	102 S. Mauldin	Ave.		21901		Ţ	Inited	l States	5
	dea	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14.	Race - Americ Black, White,	an Indian,
36	or It.	by Funeral Director	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes 2 If Yes, Give	□No1944-	1 ☐ Yes 2 📉 N		,		pecifyWhite	
21215-0036	hour tural	ed b	15. Decedent's	Year or Date	1740	dent's Usual Occ	aupation.			of Business/Inc	
15	n *na	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	(Give		e during most of	working			,
212	d with	Completed	Elementary/Secondary (0-12)	4		ice Mana	ger		Trai]	ler Sale	es
Maryland	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It is Medical Examble in critical at an once.	To Be (17. Father's Name (First, Middle, L. William Nast Bu				1	_{Name (First, Middle,} le Parks	Maiden Su	ımame)	
lary	2 shou and M Is mar aumat		19a. Informant's Name/Relationshi			ng Address (Stre	et and Number or	Rural Route Numbe	r, City or T	own, State, Zîp	Code)
	and lealth m 27 har tr		Bonnie L. Black	we11/daugh	nter 102 S		n Ave.	North Eas		ryland	
Baltimore,	Pages 1 nent of H int: If ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Other (See		ate North Ri	matory or other p dge Ceme	tery Feb	ruary 3,	Cambr	ia, NY	wii, State
Balti	permit. Departri Importa any inju		21. Signature of Experiment Service Li	Lu		Crouch Fur			901		
23a. Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervolved in the disease or condition resulting in death) Physician (Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											Approximate Interval Between Onset and Death UNKNOWN
1760,	eath certificate be executed attending physician and attending physician and for use as the buriat-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):						
.O. Box 68	the death certifica y the attending ph sched for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 Fetal death 3 at at time of death 5	□Ectopic pregnar □ Other (specify)			230	d. Date of delive Month	ory Day Year
ds, P	requires that the de een signed by the a hould be detached f	by	Part II. Other significant condition	s contributing to deal	th but not resulting in the u	inderlying cause	given in Part I.			contribute to the	ne cause of death?
Records,	e law has b ye 2 sl	Completed							rmed?	prior to cou death?	psy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of I	1 ☐ Yes Death (Check only o		1 🗆 165	20110
N.	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 🗆 Inp	patient 2 ER/Outpatie	nt 3 DOA		g Home 5 Resid		Other (Specify	y)
on of	ing life		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury 28b. Time of Injury	W		28d. Describe I			
Division	if or Attendi after death, Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place 01	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, offic	e	28f. Location (S City or Tox		Number or Rura	i Route Number,
	To tha Hospital or Attendli within 24 hours after death, To tha Funaral Director: A completely filled in by the fu	Medical C	29a. Certifier	Physicien: To the be xeminer: On the bas and manne	est of my knowledge, deat is of examination and/or in r stated.	h occurred at the vestigation, in m	time, date and pl y opinion, death o	ace, and due to the ccurred at the time,	cause(s) ar date and pl	nd manner as stace, and due to	tated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	-		29c. Lice	nse number		29d. Date s	signed (Month,	Day, Year)
			Ih OL	1.			D52739		JANU	ARY 28,	2006
-	- 1		30. Name and address of person w								
5	HIVA		SURESH SHANDELY	YA, M.D.,	VA MARYLAND	HEALTH (CARE SYS	TEM, PERR	Y POI	NT, MD	21902
	Sta Registi		31. Date filed (Month, Day, Year) JAN 3 (2006	distrar's Signature	parle					

DHMH 17 Rev 1/2001

NAME KNOWN TO PHYSICIAN: BURMASTER, WILLIAM J

	Registrar		Maryland dr., G85	Cer	tificate	of L	<i>Death</i>			Reg. No.			
	1. Decedent's Name (First, Middle, La.	st)							2. Date of D Month		/ Year		of Death
an cal	Guy Huffmyre But								Januar			2:0	0P M
ner								of Death			,		
				hirthday				24 Hrs	9 Data of B				
	217-28-2210		74	Yrs.			Hours	Min.	July 1	0 19:	C	ountry)	
	10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside	City Limit
ō	MD Frederic	ck.										1 🗌 Ye	es 2 🙀 N
rec	10e. Street and Number					Code				10g. Citi	zen of What C	ountry?	
0	5903 Laurel Court	Ė			21	710					USA		
ner	11. Marital Status				Vas Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or N	0-			
by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 [If Yes, Give	^{□ No} Peace•	- 1		_	Specify:	, 1 00110	noun, oto.,		Specify:		
ted	15. Decedent's Ed	ducation	1	6a. Deced	lent's Usual	Occupa	tion			16b. Ki	nd of Business	:/Industry	
ple			or 5+)	(Give I life. E	kind of work OO NOT use	done d retired)	uring most	of worki	ng	Uni	ted Mas	onry	
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	- Manual I	T. VUCC	wner	_ Jc	ohn T.	Wi.	lliam	s Fu			ck, MD	21716	
Y I	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caus one cause on each	ed the death. D	()				r respiratory a	arrest,		Approxim Interval B	etween
	Immediate Cause (Final disease or condition			r	her	m	م بر	_ ,					lain
	resulting in death)	Due to (or a	as a consequenc	e of):									1
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dic		d											
/Me	IF FEMALE:										23d. Date of de	livery	
clar	in the past 12 months?										Month	Day	Year
ysi	9 Unknown	9□ Unknown											
		_	but not resulting	g in the un	derlying cau	ise givei	n in Part I.		23e. Did	tobacco u	se contribute t	o the cause of	f death?
ed	1°an	Mson	1 D	The	ase	-			10	Yes 2	X No 3 □ P	robably 4	_Unknow
plet											24b. Were a	utopsy finding	s availabl
Eo									_ perfe	ormed?	death?		cause of
0	25. Was case referred to medical						26. Place	of Death			1.0.10.	20110	
0	examiner?	Hospita Inpa	tient 2 ER/	Outpatient	3□ DOA	1 -	-				Other (Spe	ecify)	
	27. Manner of D ath	28a. Date of In	njury 28b		280	. Injury	at ?	2	8d. Describe	how injur	y occurred		
atle	Accident investigation				М	1 🗆 Y	es 2 🗆 N	10					
ertific	4 Homicide determined	280. Place of I	njury - At home, etc. (Specily)	farm, stre	et, factory,	office		2	8f. Location (City or To	Street and wn, State	d Number or R)	ural Route Nu	mber,
	29a Certifier Certifying Phy	veician: To the hea	st of my knowled	lae death	occurred at	the time	data and	t place a	nd due to the	071100/0)	and mannas a	a state d	
dica	(Check only Medical Exam	iner: On the basis	of examination i	and/or inv	estigation, in	my opi	nion, death	h occurre	d at the time,	date and	place, and du	o to the cause	(s)
Me	29b. Signature and title of certifier	2			29c.	License	number			29d. Date	a signed (Moni	h, Day, Year)	
		144	MAN			DI	471	69	J	lanua	ry 31,	2006	
- 1		2 /1 ////				-							
	30. Name and address of person who of	completed cause of	death (Item 23a strar's Signature) (Type. P	Print)	WIRE		-I		_			
	edical Certification: To Be Completed by Physician/Medical Examiner	4a. Facility Name (If not institution, given Frederick Memoria Scale Security Number 217-28-2210 Usual Residence of Decedent 10a. State 10b. County MD Frederic 10e. Street and Number 5903 Laurel Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grave) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Guy Franklin Butt 19a. Informant's Name/Relationship (Institution) 20a. Method of Disposition 1 Burial 2 Gremation 3 Laurel Court 21. Signatur (Fur Seprice Licenter) Parbara A. Wi. 23a. Part Enter the disease, or companded to shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (The cause (Disease or injury that initiated events resulting in death) 19 Cause (Disease or injury that initiated events resulting in death) Last 19 Cause (Disease or injury that initiated events resulting in death) Last 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions or conditions or condition	Sala Sala	Supering the present of the presen	a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 217-28-2210 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Frederick Adamstown 10b. Street and Number 5903 Laurel Court 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Amad Forces? 12. Marital Status 13. Marital Status 14. Marital Status 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 16. Street Individual Last) 16. Street Individual Last) 17. Father's Name (First, Middle, Last) 18. Informant's Name/Pleatationship (Type, Print) 19. Mallin 19. JoAnne Butts, Wife 20a. Method of Disposition 10a. Street Individual Last) 19. Street Individual Status 19. Parbara A. Williams, Uwner 10a. Street Individual Status 19. Parbara A. Williams, Uwner 10a. Street Individual Status 19. Parbara A. Williams, Uwner 10b. Decedent Individual Status 19. Parbara A. 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County Months Days Hours Min. July 10b. Street and Number 10c. City, Town or Location MD Frederick Adamstown 10c. Street and Number 10c. Street and Number 10c. City, Town or Location MD Frederick Adamstown 10c. Street and Number 10c. Street and Number 10c. City, Town or Location MD Frederick Adamstown 10c. Street and Number 10c. Street and Number 10c. City, Town or Location MD Frederick Adamstown 10c. Street and Number 10c. City, Town or Location MD Frederick Adamstown 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10	4a. Facility Name (if not institution, give arread and number) Frederick Memorial Hospital Social Social Social Memorial Hospital 100 City, Town or Location 101 Zep Code 217 10	Secolar Secolar Prederick Memorial Hospital Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Secolar Prederick Secolar Preder	Seculty Name (Price mattheon; over street and number) Frederick Frederic

			1 For State Registrar	State of M	/larylan		artmen rtificat			and M		giene Reg. No.	006	03961
			Decedent's Name (First, Middle, La	ist)	· · · · · · · · · · · · · · · · · · ·					1	2. Date of Dea	ıth		3. Time of Death
	Physici /Medi		Lillian Broccol	ina							Februar	ry ^{□ay} 6	2006	1710 M
	Examir		4a. Facility Name (If not institution, give	e street and numbe	r)		4b. City,	Town, or	Location o	f Death			nty of Death	
			Carroll Hospita						nster				Carro	
	Funeral Director		213-28-2652	Sex 1 □ M 2 🔀 F		75 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birtl Month, Day Feb 07	1930	9. Birthy Cour	place (State or Foreign MD
700	A		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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\$ \$	r 28.	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cour	ntry?
4	238 0	a D	808 Uniontown F	Ro ad				211	.58			1	USA	
d 21215-0036	ital Hygiene. Ital Hygiene. dother than "naturel", or items 23s or 28e-1 ehow event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 200 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 ☐ Yes 2 15 If Yes, Give Year or Dates	s? ☑No	1	Was Deced f Yes, spec l ☐ Yes		spanic Origin, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. R Spec	lace - Americ lack, White, city: Wh	
	natur	Completed	15. Decedent's E			16a. Dece	dent's Usua kind of wo	al Occupa	tion uring most	of workii	na	16b. Kind of	Business/In	dustry
7	Man .	mple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	se retired,			.9	Or 200	Homo	
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and	a a a	To Be	Eli Goldstein	,							ed Stick		amej	
Maryland 21215-0036	other traumatic ev	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	i Route Numbe	r, City or Tou	m, State, Zip	Code)
	n 27 i		Sebastian Broccol	ina/husba					Road		estminst			
Baltimore,	or oth		20a. Method of Disposition 1 DBurial 2 Cremation 3 C		_ C6	lace of Dispo	natory or o	ther place			ate L/2006	20c. Location		
			4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		Lak				,		-			TID .
Balt	ded Fig		Al K.A	1-el							e and Ch d Westr			21157
			23a. Part. Enter the disease, or com	plications that saud	ed the death									Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition			RYF	RTE	RY	DI	SE	ASE			Onset and Death
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X Sartific	ettending p	/Me	IF FEMALE:	23c. If yes, outcom	e of oregnar	ncv			-		-	224 [Date of delive	201
. Box 68/60,	d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth 4□Pregnant	2 Fetal	death 3	Ectopic produced of the control of t					1	Jate of delive	Day Year
j i	by the tache	hys	9 ☐ Unknown	9□ Unknown										
ທ໌ ສ	been signed by the should be detached	þ	Part II. Other significant conditions of DIA BITIS	MELL	but not resu	ulting in the ur	nderlying c	ause give	n in Part I.			bacco use co es 2 □ No		ne cause of death?
စ္က	es be	Completed									24a. Was a	in 24t	. Were auto	psy findings available mpletion of cause of
		Con									perform	med? 2X No	death? 1 🗌 Yes	
VITAL	sartific actor.	Be	25. Was case referred to medical examiner?	Hospital:				0%-		of Death	(Check only or	10)		
5 a	this ral dir	은	1 Yes 2 No 27. Manner of Death	1 L Inpa	-/-	PVOutpatien 28b. Time of			4 🗀 Nui		ne 5 Reside			y)
	th. : After	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	м	8c. Injury Work 1 ☐ Y	? es 2 □ N		.55. 2555.155 11	ow injury coo	uoo	
DIVISION ai or Attending	within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of 1	njury - At hor etc. (Specify,	me, farm, stre	eet, factory	, office		2	8f. Location (Si City or Town	treet and Nur n, State)	mber or Rura	l Route Number,
• Hospit	24 hour. • Funer letely fille	edical (29a. Certifier (Check only one) Certifying Ph	ysician: To the bes niner: On the basis and manner	of examinati	vledge, death ion and/or inv	occurred estigation,	at the time	e, date and inion, deat	d place, a	and due to the co	ause(s) and r late and place	manner as st	lated. the cause(s)
Tota	withir To th comp	Me	29b. Signature and title of sertifier				290	License	number		2	9d. Date sign	ned (Month,	Day, Year)
)	1		12				1	Dr.	372	-5		21	710	6
	(D) (D)		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)		4		. 27	(7)	MID	21221
	3 7		31. Date filed (Month, Day, Year)	32. Regis	LU [-]	ure (5 ac	E 1	1v47	Vec	10 3 CC	1 150	(thim	we
	Sta Registr		FFB 0 7	2006	lider	14	Longe	E						

CPM 06-00882 Daryk Bush

Unpend item#23a,27,22a-f,pen.ff, 22,216/06 III. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O4, Month February 2006 12:05 PM **Physician** Jourdan Bush /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year)) | 9. Birthplace (State (Month, Day, Year)) | 1987 | Mary Land 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 221-78-3944 18 Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Bel Air Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21015 USA Itama 23a 1510 North Fountain Green Road Completed by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pressure Washer Car Wash 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of parmit. Pages 1 end 2 should be Deportment of Health and Mental Important: If itsm 27 is marked any injury or other traumatic avone. ဥ McGlothlin Virginia Rae Bush Nicholas Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 North Fountain Green Road, Bel Air, MD 21015 Virginia R. Bush - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/09/06 Towson, Maryland Hilltop Serv. Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 uscell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final **Physician** disease or condition resulting in death) Oxycodone and methlenedioxymethamphetamine (MDMA) intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ri any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-transit or Attanding Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ö Month Day

Completed by Physician/Medical certificete has been s irector, page 2 should within 24 hours after deeth. To tha Funeral Diractor: After this certific completely filled in by the funeral director, Be ၉ Certification: Medicai

in the past 12 months? 4☐Pregnant at time of death 9 Unknown 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

autopsy performed? 2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

25. Was case referred to medical examiner? 1X Yes 2 □ No 27. Manner of Death 1 Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Fnd Injury 2/4/2006 11:30

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 🏋 No

28d. Describe how injury occurred unk

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4303 Security Lane Jarrettsville, MD

111 Penn Street, Baltimore, Maryland 21201

Jarrettsville, found in car Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

February 05, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TORK M. TITE, 31. Date filed (Month, Day, I O 2006

MiD 32. Agistrar's Signature

State Registrar

Hospital

ratri		ı I	Bednarczyk Please T Unpend item#23a,	ype or Print in F 27,28a-f.pen/E,G State of Marylan	Black In 852,2/10	delible In	k. Ensure A	II Copie	s Are	Legible.		
crn		_	1 - For State Registrar	State of Marylan		artment of tificate of		Mental H	ygien Reg. N	UUU	039	163
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	D	ay Year		of Death
	/Medic		Patricia Ann Be					Februa		05, 2006		45 A M
	Examin	er	4a. Facility Name (If not institution, give s 517 Twinbrook Lar			Joppa	or Location of Deatl	1	4	c. County of Death Harford	1	
2	Fundani		5. Social Security Number 6. Sex		last birthday)	If Under 1 Yea	r If Under 24 Hrs.		lirth		place (State	e or Foreign
	Funeral Director		213-52-7688 Usual Residence of Decedent	M ¥□F 48	Yrs.	Months Day	s Hours Min.	Apr.		1957 Mar		
	hours after death with the Maryland tural', or Iteme 23a or 28a-f ehow al Examinar must be notified at	Same .	10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside	- ,
	d within 72 hours after death with the Marylan piene. r then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at	Director	Maryland Harford	J	oppa	1						es 2 No
	with if		10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cou	intry?	
	eath	Funeral	517 Twinbrook La	NE 12. Was Decedent Ever in U.	S. 13. V	+	085 Hispanic Origin? (S	pecify Yes or N	10-	USA 14. Race - Amer	ican Indian.	
(0	riter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	'	Yes, specify Cu	ban, Mexican, Puert	o Rican, etc.)		Black, White		
036	rat', o	þ	3 ☐Widowed 4√€ Divorced	If Yes, Give Year or Dates:		I⊡Yes 2∱ZN	o Specify:			Specify:	White	
2-0	72 hc	eted	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occ kind of work don	e during most of wor	king	16b.	Kind of Business/li	ndustry	
Baltimore, Maryland 21215-0036	within 72 ene. then "nal	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retir	,				_	
7	e filed with Il Hygiene. other ther vent, the N		12 17. Father's Name (First, Middle, Last)		Machi	ne Opera	18. Mother's Nar	ne (First, Middl		iling Mai	nufact	urer_
and	9 7 5	To Be	James John Bedn	arczyk				•		Kryglik		
Ž	should Ind Men	ř	19a. Informant's Name/Relationship (Ty)		19b. Mailir	g Address (Stree	at and Number or Ru			- M. M.	p Code)	
Ž	and 2 Baith a n 27 is		Nichole R. Norris	/ Daughter	517	Twinbro	ok Lane, i	Joppa, I	MD 2	1085		
Je,	T SE SE SE SE SE SE SE SE SE SE SE SE SE		20a. Method of Disposition	1 0	lace of Dispo	sition (Name of natory or other pi		Date		Location - City or T	own, State	
<u><u>E</u></u>	Pages nent of ant: If it ury or o		1 ☐ Burial 2XI Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Hil	ltop S	ervice (Corp. 2-8-	-06	Tor	wson, Mai	ry1and	1
alt	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License	98	133 M	Name and Add	ess of Facility Funeral Ho	ome, P.A	Α.			
	80559		JUSTY (1/ALLY	ill	1	317 Coke	sbury Roa	id, Abir	ngdo	n, Maryla		1009
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not ent	er the mode of dy	ring, such as cardiac	or respiratory	arrest,	-	Approxim Interval B Onset an	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Oxycodone Intoxi	cation						Onset an	J Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
	₹′	-	Sequentially list conditions, b	Due to (or as a consequ	ianes offi							
	and I-transit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(0.000								
	execu in and rial-trai	Еха	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):					-		
760	e be /sicia e bur											
89	eath certificate be exatted by exatted and physician for use as the burian	Medi										
ŏ	th cer endir r use	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnal		Ectopic pregnan	cv			23d. Date of deliv	-	
Э.	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)			- 1	Month	Day	Year
P.0	that the de ed by the detached	by Physician/Medical	9 Unknown Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderbing cause o	wen in Part I	23e Did	tobacco	use contribute to	the cause o	f death?
Division of Vital Records, P.O. Box 68760			,			,doi.ya.g oddoo g			Yes 2			Unknown
. 03	been shou	Completed						24a. Wa	s an	24b. Were aut	onsy finding	is available
Re	The lav	Ę.						auto perf	opsy formed?	prior to co	impletion of	cause of
<u>a</u>		e C	25. Was case referred to medical			· · · · · · · · · · · · · · · · · · ·	26. Place of Dea		2 N	o 1 🗷 es	2∐ No	
5	Physician: this certifier ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	3 DOA O				6 Dother (Speci	w at	scene
2	g Ph	Ë	27. Manner of Death	28a. Date of Injury Fnd (Month, Day Year)	28b. Time of Injury	Fnd 28c. Inj		28d. Describe			,,	
Ö	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation		40 10		TV OF NA	unk_				
Ξ̈́	or Atta	Certification:	3 ☐ Suicide 6 ☑ Could not be 4 ☐ Homicide Adetermined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	et, factory, office		28f. Location City or To	(Street a own, Stat	ond Number or Rur 19317 Twinbr	al Route Nu	m <i>ber</i> ,
Ω	urs of urs of rei D			found at home				soppa, III				ic
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerei Director: Affer this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☑ Medical Exemin	icien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	cause(s , date an	s) and manner as a nd place, and due t	stated. o the cause)(s)
	To the within 2 To the complet	Med	29b. Signature and title of confiler	and marrier stated.	^	29c. Licer	nse number		29d. Da	ate signed (Month,	Day, Year)	
	F ₹ F 0		Not Dies	211-1201	10	(O.C.M.E.		Feb	ruary 06,	2.006)
			39. Name and address of person who co	mpleted cause of death (Item		Print)		1				
			PATRICIA Aronica	FOLLAKM	0 111	Penn St	reet, Bal	timore,	, Mai	ryland 21	201	_
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture							
	Registra	ar	FEB 1 0 200	16 /	K Sa	16.3						

DHMH 17 Rev 1/2001

ORIGINAL

	1	For Stete Registrar	State of	Maryland	•	artment rtificate			and M	ental H	ygier Reg. f	2006	(03964
n. I. i.	_	Decedent's Name (First, Middle, in the control of the control	Last)			_				2. Date of D		Day Ye	ar	3. Time of Death
Physicia /Medica		Viola Harrison	Burke							Janua	ry 2	25, 200	6	12:25 ^{a м}
Examine		4a. Facility Name (If not institution, g		ber)		4b. City, T						4c. County of [
		Holy Cross Hosp						er Sp				Montgo		
Funeral Director		577-10-6990	. Sex 7 1 □ M 2 ② F	'. Age (In yrs. Ias 92	st birthday) Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of B (Month, E Sept.	irth 24, Yea 12,	9. 1913	Count	ace (State or Foreigr try) rginia
pua *	-	Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	eation							10	Od. Inside City Limits
Maryl f eho	٥	Maryland Monto	omery	Cil	***** G	Spring								1 ☐ Yes 2 ☐ No
the 28a	Director	10e. Street and Number	Omery	511	VEL	10f. Zip (code				10g.	Citizen of Wha	t Count	try?
h with	a D	10617 Tenbrook D	rive			209	901					US	A	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Ford	² ₩ No	1	Was Decede f Yes, specif 1 Yes 2		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - A Black, V Specify: W	Vhite, e	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours at lith and Mental Hygiene. 77 ie marked other than "natural", or traumatic event, the Medical Exert	Completed	15. Decedent's (Specify only highest	Education			dent's Usual kind of work			t of worki	na	16b	. Kind of Busin	ess/Ind	lustry
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mark matic	္	19a. Informant's Name/Relationship	(Type Print)		19h Mailir	na Address /	Street		nown	l Route Num	her Cit	y or Town, Sta	te Zin	Code)
Ma id 2 s id 2 s id 2 s id 2 s itraul		Robert A. Burke/												A 30176
Baltimore, Sermit. Pages 1 ar Department of Hea mportant: if item; any injury or other		20a. Method of Disposition	□0	con	ce of Dispo	sition (Name	e of er place	в)	Jan	Date 28,	20c.	Location - Cit	y or To	wn, State
Page ment of pury of p		PD Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Park		Memor			2	006				aryland
Ball permit Depart Import eny in once.		21. Signature of Funeral Service Lin	Lali	e	F ² 1	Name and ancis O Uni	Addres vers	Sity	ins i Blvd	Funera , W, S	l Ho ilve	ome Inc er Spri	ng,	MD 20901
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ca ly one cause on ea	used the death. ch line.	Do not ent	er the mode	of dying	g, such as	cardiac d	r respiratory	arrest,			Approximate Interval Between Onset and Death
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uted ansit	E I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			·									
8760, sate be executed by sician and the burial-transit	ai Exa	resulting in death) Last	C. Due to (o	or as a conseque	nce of):									
68/ ifficate g phy as the	edic		u											
VISION Of VITAI RECONDS, P.O. BOX 68/60, Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	ome of pregnand th 2 Petal d int at time of dea wn	eath 3[Ectopic pre Other (spe						23d. Date of Month		ry Day Year
	by Ph	Part II. Other significant condition	s contributing to dea	ath but not result	ing in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacc	o use contribu	te to th	e cause of death?
ords	Ped	Urinary Tract I	nfection,	, Dehydr	ation	1				1] Yes	2 No 3] Proba	ably 4 ⊠Unknown
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ISION C Mtending P death. ctor: After I y the funera	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month	finjury 2 n, Day Year) 2	8b. Time o Injury	f 28	c. Injury Work	rat ⟨? Yes 2 🔲		28d. Describe	e how in	njury occurred		
DIVIS all or Atte s after de in Directe od in by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place (of Injury - At hom g, etc. (Specify)	ie, farm, sti	eet, factory,	office			28f. Location City or T			or Rura	l Route Number,
	edicai (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the baseminer: On the base	sis of examinatio	edge, deat on and/or in	h occurred a vestigation, i	t the tim	ne, date an pinion, dea	d place, a	and due to the	e cause e, date	e(s) and manne and place, and	er as st due to	ated. the cause(s)
Totl within Totl	Σ	29b. Signature and title of certifier	R				License	number 32				Date signed (A anuary		
10		30. Name and address of person who Suresh K. Gupta,		of death (Item 2 801 Geor			, #2	220,	Silv	er Spr	ing	, MD 20	902	
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			1 - For State Registrar	State of M	laryland / Depa <i>Cel</i>	artment of rtificate of			iene	03965
	Physic	ian	Decedent's Name (First, Middle, Last) The second of the second of			÷		2. Date of Deat	h Day Your	3. Time of Death
	/Medi	cal	James Berkovi 4a. Facility Name (If not institution, give s		3	4h City Tourn	or Location of Death		25, 2006	1:15 p M
1	Exami	ner,	4910 River Road	stroot and nameer)	'	Bethes			4c. County of Death Montgomer	v
	Funeral		5. Social Security Number 6. Sec		ge (In yrs. last birthday)	If Under 1 Yea Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth	O. Bi-th-	place (State or Foreign
	Director		210.10.4055]M 2□F	87 Yrs.			July 20,	1918 Penns	ÿĺvania
	ryland how		10a. State 10b. County		10c. City, Town or Lo				1	0d. Inside City Limits
	8e-fs	Director		ry 	Bethesda					1 ☐ Yes 2 No
	with ti	Pr	10e. Street and Number 4910 River Road			10f. Zip Code	0816	10	0g. Citizen of What Cour	itry?
	death ms 23	Funeral		12. Was Decedent	Ever in U.S. 13. 1		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	U.S.A.	an Indian,
36	72 hours after death with the Maryland netural', or Itams 23a or 28e-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1/1 Yes 2 If Yes, Give	No Navy	IYes, specify Cu 1 □ Yes 2 □XNo		Rican, etc.)	Black, White, Specify: Whi	
Ö	hours tural',	ed b	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates:	MMTT	dent's Usual Occi				-
215	hin 72 an "ne Medic	Completed	(Specify only highest grade		(Give		e during most of work	ring	16b. Kind of Business/Ind	Justry
21	ygieneyjanayjanarth	Соп	Elementary/Secondary (0-12)			rbine Ma	itenance		Potomac Ele	ctric Co.
Maryland 21215-0036	d be fi	o Be	17. Father's Name (First, Middle, Last) Peter Berkovic	ch			18. Mother's Nam	e (First, Middle, N Detelich		
aryl	shoul ind Me s mark umati	2	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Stree			City or Town, State, Zip	Code)
	and 2 ealth a n 27 is		Louise Berkovich/	Wife	4910	River R	oad Bethe	sda, Mary	yland 20816	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	,	20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Re	emoval from State	1 .	natory or other pl	ace)		20c. Location - City or To	
Ħ	artment ortant: injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Financial Sorvice License	6	Gate of I		Jan.	30,2006 S	Silver Sprin Ler's Sons,	ng, MD
B	Depar Depar Impor any ir		1 State C	lew			onsin Aver			1.11.0
HONE AND	Frysician /Medical Examiner		23a. Fart1 Enter the disease, or complication, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Renal Due to (or as	d the death. Do not entende. Cell Carcinal a consequence of):					Approximate Interval Between Onset and Death
8760,	ficate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, a y leading to inmodels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
Box 6	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	ру		23d. Date of deliver Month	ry Day Year
rds, P.	The law requires that the steep has been signed by the page 2 should be detached.	by	Part II. Other significant conditions cont Chronic Obstructive						acco use contribute to the	
Il Records,	The law recate has be page 2 she	Completed						24a. Was an autopsy perform	prior to comed? death?	osy findings available appletion of cause of
Viita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		0:	26. Place of Death	(Check only one)	
Division of Vital	Phys this al dii	lon: To	27. Manner ol Death 1 X Natural 5 ☐ Pending	1 ☐ Inpatie 28a. Date of Inju (Month, Day	ont 2 ER/Outpatient ry (Year) 28b. Time of Injury	28c. Inju Wo	ry at ::	me 5 NR Residen 28d. Describe how	ce 6 □Other (Specify, vinjury occurred	1
/ISI	r Attano er death rector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, stre]Yes 2□No	28f. Location (Stre	eet and Number or Rural	Route Number
á	rs afte al Dire ed in b	Cert	4 🗋 Homicide determined	building, etc	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	riodio ivanibor,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1	cian: To the best of er: On the basis of and manner sta	examination and/or invi	occurred at the t estigation, in my	ime, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as sta e and place, and due to	ited. the cause(s)
	To To Com	2	29b. Signature and title of certifier		>		se number 035579		d. Date signed (Month, Danuary 26,	
	5		30. Name and address of person who con Susan J. Miller, 1	mpleted cause of de M.D. 684	eath (Item 23a) (Type, F 44 Tulip Hi	r _{int)} 11 Terra	ace, Bethe	sda, Mar	yland 20816	
À	Sta Registr		31. Date liled (Month Pay, Year) 711	32 Registra	ar's Signature	sell				

			1 - For State Registrer		*	ertificate of		ental Hyg Re	2006	03966
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Deat Month		3. Time of Death
F	hysicia Medic/		Ronald David Be	enden				JANUARY	21, 2006	9:35P. M
	Examin		4a. Facility Name (If not institution	n, give street and number	er)	4b. City, Town, o	or Location of Death		4c. County of Dea	ath
			926 BEACON SQUA		[‡] 332		RSBURG	7	MONTGOME	
	uneral		5. Social Security Number 166–32–1785	6. Sex 7 1 1 2 M 2 □ F	Age (In yrs. last birthda 65 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, June 4,	1940 Pen	thplace (State or Foreign ountry)
	rector		Usual Residence of Decedent		65 113			Julie 4,	1940 Fell	nsýlvania
yland	Mod		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Mar	lied Bed	tor	Maryland Montgo	omery	Gaither	sburg				1⊠Yes 2□No
th the	or 28	Director	10e. Street and Number	_	"	10f. Zip Code			0g. Citizen of What C	
ath w	230	rai	926 Beacon Squ	uare Court,		20878			Jnited Sta	
be filed within 72 hours after death with the Maryland tal Hygiene.	nd other then "neturel", or Iteme 23e or 28e-f show event, the Medical Examinet must be notified at	by Funerai	11. Marital Status 1★ Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, Give	ss? □No	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
72 ho	lical	Completed	15. Deceden	t's Education st grade completed)		cedent's Usual Occup ive kind of work done		ina	16b. Kind of Business	s/Industry
ithin ie.	- N	npie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	a. DO NOT use retire	d)		_	
led w			47 Falls de Name (Cine Middle	2	Sta	ff Photogr			efense Co	ntractor
t be fi	to pe	Be	17. Father's Name (First, Middle, John David Bene				18. Mother's Name Martha L		,	
hould Me	mark	10	19a. Informant's Name/Relations		19b Ma	ailing Address (Street	L			Zin Code)
end 2 s	m 27 is ner trau		Alice M. Leish		1 Rep. 926	Pointer R	lidge Driv	e, Gaith	nersburg,	MD 20878
Pages 1	Important: if Item 27 is marked other then 'eny Injury or other traumatic event, Ins Me once.	,	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (S		ite Metro	sposition (Name of trematory or other pla POLITAN rium, Inc.	៚ Janua	-	20c. Location - City o Alexandr Virginia	
permit. Depert	eny ini		21. Signature of Funeral Service	+		22. Name and Addre	ess of Facility DeV			g, MD 20877
			23a. Part 1/ Enter the disease, or shock, ar heart failure. List							Approximate fnterval Between
Phys	sician		Immediate Cause (Final disease or condition	A .				9	(Onset and Death
	Medical xaminer		disease or condition resulting in death) a. ATHENOSCIENCE CANDIO VAS CILLIN DISEASE Due to (or as a consequence of):							
Exa			Sequentially list conditions, b							
po	sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury)							
xecut	and I-trar	an		•						
8 8		×	that initiated events resulting in death) Last	c	as a consequence of);			-		
-	sicien buria	al Ex	that initiated events	cDue to (or	as a consequence of):					
ificate	physicien and as the burial-transit	edical	that initiated events	c	as a consequence of);					
h certificate t	anding physicien use as the buria	edical	that initiated events	d23c. If yes, outcor	me of pregnancy				23d. Date of de	slivery
e death certificate t	attending for use as	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	me of pregnancy 2 Fetal death t at time of death	3 ⊟Ectopic pregnanc 5 ⊟ Other (specify) _	y		23d. Date of de Month	blivery Day Year
nat the death certificate t	attending for use as	dical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	me of pregnancy 2 Fetal death t at time of death	5 Other (specify)		220 Did tok	Month	Day Year
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			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 0 0 6 0 3 9 6								03967			
			Registrar 1. Decedent's Name (First, Middle, Las							. Date of Death	Reg. No. 3. Time of Death			
	Physicia	an				רא ער	110				Month ANUARY	Day	Year	12.30p M
	/Medio Examin		EDITH 4a. Facility Name (If not institution, give	ROBERTA street and number)		BAKE		, Town, or	Location of		ANUARI	27 200 4c. County		1 +2,30p
	Examin	EI	Frederick Memoria				Fre	deri	ck			Fred	leric	k
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last	birthday)	If Unde	Days	If Under 2	Min. 8.	Date of Birth	Year)	9. Birth	place (State or Foreign ntry)
	Director		210 30 7013	⊐м 2 X ДF	80	Yrs.		July	1,00.0		arch 25			ry1and
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	Aaryla f sho	5	Maryland Carroll		Мон	nt Ai	rv							1 ☐ Yes 2 ☐ No
	the t	Directo	10e. Street and Number		11041	110 111		p Code			10	g. Citizen of	What Cou	ntry?
	3a or		615 Calliope Way					2177	1			U.S	S.A.	
	death	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Dece	edent of Hi	spanic Orig	in? (Specif	y Yes or No- can, etc.)		ce - Ameri ck, White,	can Indian,
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 ZNNo If Yes, Give	0	i	1 🗍 Yes		Specify:		,	Specif	T 71	
Ö	fied within 72 hours after death with the Maryland Hygiene, Hygiene, then "natural", or Item 23e or 28e-f show ther the Madical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1 1	Sa Dassa	tanka 1 ka	al Oscure	tion			16b. Kind of B		dustri
2	"nat	iete	15. Decedent's Ed (Specify only highest gra-	de completed)		(Give	kind of w	ual Occupa ork done d use retired	furina most	of working		16b. Killa oi b	n2111622/11	idustry
72	withi lane. then	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Hot	nemal	cer				C	own H	ome
D	Hyg other		17. Father's Name (First, Middle, Last)						18. Mother	r's Name (F	First, Middle, N	faiden Sumar	ne)	
Maryland 21215-0036	uld be Menta riked rilc ev		J. Raymond K	emp					М.	Fra	nces F	ing		
lan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene.		19a. Informant's Name/Relationship (7	ype, Print)	1	9b. Mailir	ng Addres	is (Street a	and Number	r or Rural F	Route Number,	City or Town	State, Zip	o Code)
≥,	and ealth m 27		C. Oscar Baker -	Husband	20b. Place				Way,	Mount	Airy,	Mary 1a		21771
9	ges 1 if of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		сете	etery, cren	natory or	other plac	1				•	
Baltimore,	t. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify 21. Sign ture of Funeral Service Licen		Pine				ry 2					Maryland
Ba	Depa Depa Impo eny l		21. Significate of Parlietar Sewice Licent	Willian	ns						P.A., F			
	_		23a. Part1. Enter the disease, or comp	olications that caused t	the death. D						amascus espiratory arre		Land	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Interval between Onset and Deatl									Onset and Death		
1	/Medical		Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of):											
	Examiner													
	פַּיָּב פַ	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying											
	ecute end I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):								-			
8760,	cate be executed bhysicien end the burial-transit	a E	To bus to (or as a consequence or).											
687	ficate physics the	edicai		g										
Box	death certifica attending ph d for use as t	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Texania i					23d. Da	23d. Date of delivery	
m	that the death cer ed by the attendin detached for use	Physician/Me	in the past 12 months? 1 Yes 2 No 1 Ves 2 No 1 Unknown										Month Day Year	
P.O.	at the	hys	9 Unknown								00 P:4::	4		
<u>ທ</u>	8 E 6	Completed by	Part II. Other significant conditions on PARKINSUNS I	ontributing to death but DISEASE	t not resultin	g in the u	nderlying	cause give	en in Part I.			d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown		
ord	w requir been si should			TOEHOL	-							1		
Sec	e law has b		DEMENTIA							_	24a. Was ar autopsy perform	24b.	prior to co death?	opsy findings available empletion of cause of
a E	icete r, pag										1 Yes 2	Ø No	1 🗆 Yes	2□ No
₹	sicla: certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	examiner?								dence 6 □Other (Specify)		
ð	g Phy er this	ت. 1	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 2						28d. Describe how injury occurred				
<u>0</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	y Work? M 1 ☐ Yes 2 ☐ No		4o						
Division of Vital Records,	or Atterder de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home (Specify)	, farm, str	eet, facto	ry, office		28	t. Location (Str City or Town	reet and Numi , State)	er or Rur	al Route Number,
Ω	oital ours af													
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		iner: On the basis of and manner stat	examination									
	To the within To the comple	Me	29b. Signature and title of certifier				25	c. License	e number		29	d. Date signe	d (Month,	Day, Year)
	1		title LAN	HVINDER V	VADHW.	A		Doo	6340	18		1/28	106	
			30. Name and address of person who	completed cause of de	ath (Item 23	a) (Type,		a.	_			-		701
	-		Lakhvinder Wadh	va, M.D.			/th	stree	t, F	reder	ick, Ma	aryland	1 21	701
	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 0	2006 22. Heading			hour	11						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item #6.perFH.G853.3/2/06 TT

		1	Afficiate of Maryland / Department of For Registra AMEND#7 per FH1/30/06, EMW, McCo Afficiate of Maryland / Department of For Registra AMEND#7 per FH1/30/06, EMW, McCo Certificate of		ental Hygier Reg.	2 11 11 10	03968				
	Physicia		1. Decedent's Name (First, Middle, Last) ERNEST CORBETT		2. Date of Death Month Jan 2	25, 2006	3. Time of Death 2:45 P M				
1 A	/Medic Examin	al		or Location of Death		4c. County of Death					
	Examin	Ċ.		Rockville			mery				
	Funeral Director		5. Social Security Number 6. Sex 1 M Age (In yrs. last birthday) 1 Index 1 Year 93 Yrs. Oays	Hours Min.	8. Date of Birth (Month, Day, Ye Sept 13,	9. Birth Con 1912 N.	nplace (State or Foreign untry) Carolina				
	pus *	· -	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits				
	Maryia f sho	. 1	DC None Washington				1 🔀 Yes 2 🗆 No				
	r 28a	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?				
	23a c 23a c ust ba		3317 B. Street S.E. 20019			U.S.A.					
92	i within 72 hours after death with the Maryland liene. I than "natural", or Itema 23a or 28a-f show The Madical Examble must be notified at	Fur	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 ☑ No	ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.				
Ö	hours tural',	ed by	↑ Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occu	pation	16b	b. Kind of Business/l	lack				
21215-0036	S - 3	e Completed	(Specify only highest grade completed) (Give kind of work done life. DO NOT use retire Elementary/Secondary (0-12) College (1-4or 5+)	e during most of worki ed)	ng	Grocery					
d 2	Hyg the		7th Grade Handyman 17. Father's Name (First, Middle, Last)		(First, Middle, Maid						
Maryland		To B	Will Corbett	Mary							
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type(Binughter) 19b. Mailing Address (Stree	and Number or Rura	Il Route Number, Ci	ity or Town, State, Z	20019				
	1 and Health hm 27 ther tr		Mary C. Richardson 3317 B. S 20a. Method of Disposition 20b. Place of Disposition (Name of semiletry, crematory or other place)			LINGTON D					
nor	Pages nent of the int: if its		1 Burial 2 Cremation 3 □ Removal from State 4 □ Donalon 5 □ Other (Specify) Reschaven Cem	- 1 - 1	06 Di	ınn. N.	Carolina				
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury of other traumatic and DDCs.		21. Signature of Funeral Service I service								
	Ž.		23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dy	washing ring, such as cardiac	ton St, or respiratory arrest,	COCKVIII	Approximate Interval Between				
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Solution Solution Solution Solution Solution								
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):				- dus				
36)		-	Sequentially fist conditions, if any leading to immediate b. Due to (or as a consequence of):	Λ •			20012				
		Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	4							
o,	sate be executed bysician and the burial-transit	Exa	resulting in death) Last Due to (or as a conseguence of):								
8760	ate be hysicii the bu	dlcal	d								
9	ding place as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	iverv				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specify) 1 Unknown	су		Month	Day Year				
P.O.	res that the de igned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.	23e. Did tobacco use contribute to the cause of death						
rds	w requires been sign should be	ed by	Keda bleedwa.		1 ☐ Yes	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unki					
Records,	law requas been 2 shoul	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of				
E B	sician: The law certificate has t irector, page 2 s				performed 1 ☐ Yes 2		No No				
of Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	ther	h Check only one	o 6 DOther /Soc	(n/h/)				
of	y Phys er this eral dir	n: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Time of Injury Williams 2b. Tim		ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
ion	anding lath. or: Att	atlo	2 Accident investigation M 1	☐Yes 2☐No							
Division	ai or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ө	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)				
	To the To the comp	Me	29b. Signature and title of certifier 29c. Licer	nse number	35 290	Date signed (Mon)	2006				
,	1		30. Name, and address of person who completed cause of death (ttem 23a) (Type, Print) SYCO (V. F. SX 4Y 2O 9 715 NV dila (C. 31. Date filed (Month, Day, Year) JAN 3 0 2006 32. Registrar's Signature	esta D.	Rockill	le, MD	20850				
-6	St	ate	31. Date filed (Month, Day, Year) 32. degistrar's Signature								
3	Regist	rar	JAN 3 U ZUUO								

			1 - For State Registrar	State of Maryla	nd / Depa	artment of He rtificate of D	ealth and M	ental Hyg	_	03969
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Bettu COFIN)				2. Date of Deat	24 200	3. Time of Death 7.55 A M
*	Examir		4a. Eacility Name (If not institution, give because the first second of the second of	Spital Cente	r	4b. City, Town, or/L	Source Source If Under 24 Hrs.	04/7	4c. County of De	omico
	Funeral Director		215-26-5020	7. Age (in yis	s. last birthday) 7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, January	^{Year)} 7,1929	Birthplace (State or Foreign Country) Maryland
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or	i Dir	10e. Street and Number 104A Linda Drive A	pt 4		10f. Zip Code 21826		10	0g. Citizen of What USA	Country?
036	be tited within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or Items 23a or 28a-f show event. It a Medical Evaluation man be revisited at	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 Yes 2XXIII 1 Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 🔀 No	panic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Black, Wi	merican Indian, hite, etc. Thite
21215-0036	within 72 ho ene. than "natur ta Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> Coll eg e (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of workin	ng	16b. Kind of Busines	
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event, the Me	To Be Co	8 17. Father's Name (First, Middle, Last) John Henry Quillen	No No	Homem	1	8. Mother's Name Rosa Bel	(First, Middle, N	,	
	1 and 2 sho Health and I em 27 Is me		19a. Informant's Name/Relationship (Ty, David Coffin/Son		104A	ng Address (Street and Linda Driv	e Apt4	Fruitlar	nd, Maryla	and 21826
Baltimore,	t. Pages rtment of rtent: If it sjury or c	1 13	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Carse	emoval from State	cemetery, crer COMICO Erk	sition (Name of natory or other place) Memorial	2/2/0 of Facility	6 Sa	alisbury,	
B	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e P.A. lisbury respiratory arre	, Maryland st,	Approximate Interval Between Onset and Death				
8760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicat Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		707				
.O. Box 6	that the death certifical ed by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
S, D	w requires that been signed b should be deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause given	in Part I,	I .		to the cause of death? Probably 4 □Unknown
al Record	ysician: The law requiscentificate has been director, page 2 should	Completed						24a. Was an autopsy perform	prior to death?	autopsy findings available ocompletion of cause of
Vita	ysician s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes/ 2 No	ospital:	☐ ER/Outpatien	Other	6. Place of Death		nce 6 □Other (Sp	
Division of	inding Physath. rr: After this ie funeral di	atlon: T	27. Manuar of Death 1 V Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			w injury occurred	өспу)
Divis	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special Special			City or Town,	State)	Rural Route Number,	
	To the Hospitel within 24 hours a To the Funerel completely filled	edicai	29a. Certifier 1 ✓ Certifying Phys (Check only 2 Medical Examin one)	ician: To the best of my kn T: On the basis of examin nd manner stated.	owledge, death ation and/or inv	occurred at the time, restigation, in my opini	date and place, ar ion, death occurred	nd due to the cau d at the time, dat	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	PS MA		29c. License n	umber 040	29	d. Date signed (Mor	30, 2006
	500		30. Name and abdiess of decson who con	mpleted cause of death (Ite	7 23a) (Type, 1	Hospital	1 Center	+	Salisbur	4, MD
	Sta Registr		31. Date filed (Month) Day, Year) JAN 3 0 20	32. Registrar's Sign	ature A	and the second			0	

			For State	Amend It	em Specielo		lands59		/06 5th	salth an		ntal Hyg	- 3	n.c.	03070
			Registrer 1. Decedent's Nar	me (First, Middle, I	ast)			, cr tirica	10 01	Doutin	2.	Date of Dea	eg. No. 🗍	1010	3. Time of Death
	Physicia	an		E COLBERT	,							Month / 2	27 Day 2	2006	12:32a M
	/Medic Examin			(If not institution, g		umber)		4b. City	y, Town, o	r Location of D	Death			inty of Death	
	LAGIIIII		Civi	sta Medi	cal Cent	ter			La	P1ata				Char	les
	Funeral		5. Social Security	Number 6	Sex	7. Age (li	n yrs. last birtho	Months	er 1 Year Days		Hrs. 8. Min.	Date of Birth (Month, Day GIST 1	Year)	9. Birth	place (State or Foreign Intry)
	Director		577-66-		1 M 2□F		55 Yr	S			AL	JUST 19	9, 1950	PEN	NSYLVANIA
	and		Usual Residence	of Decedent 10b. County		10	Dc. City, Town o	r Location							10d. Inside City Limits
i	Maryl f sho	Ď	MARYLANI	CHARLE	S		NEWBURG								1 TYes 2 □ No
1	r 28a	rec	10e. Street and N						ip Code			1	10g. Citiz <i>e</i> n	of What Co	untry?
SEr	172 hours after death with the Maryland "naturel", or Items 23a or 28a-f show ralical Exercitive Linust be notified at	Funeral Director	9803 SYI	VAN TURN	/ P.O.	BOX :	120		20	0664			UNITE	D STAT	res
9	ems series	ner	11. Marital Status		12. Was Dec	orces?	er in U.S.	13. Was Dec If Yes, sp	edent of H	lispanic Origin an, Mexican, P	? (Specify uerto Rici	y Yes or No- an, etc.)	14.1	Race - Amer Black, White	
98	or It			rried 2X Married	II Yes, G	2 □ No			2 X No					ecity:	BLACK
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EN RYNG nore, Maryland	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natu any injury or other traumatic event, II a Medical			Name/Relationship		er ee				and Number o					ip Code)
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2 Jours	Pages 1 nent of H int: If ite		1X Burial 2	2 Cremation 3			cemetery,	crematory or	other place	ce) ERY FFRI		1		-	MARYLAND
→ =	permit. Pages Department of Important: If i any injury or once.			5 ☐ Other (Spe Funeral Service Lic	0 0	4	GLEMA							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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			23a, Part 1, Enter	r the disease, or co	mplications that	caused the		enter the m	ode of dyir	ng, such as car	rdiac or re	espiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause disease or condit	e (Final	ily Olio Causo Oli	Cax	dienul	mon	an	1 30	res	+			Onset and Death
	/Medical		resulting in death		aDue to	o (or as a co	onsequence of)		- 1	1 00.	0 0 3				
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×	certif nding use a	N/Me	IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, or			a∏e :					23d.	Date of deli	very
ĕ	death a atter	iciai	in the past 1	2 months?	4□Preg	nant at tim	Fetal death se of death	3 □Ectopic 5 □ Other (у				Month	Day Year
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Division of Vital Records, P.O. Box	res tha igned be det	by Physician/Med	Part II. Other sign	nificant conditions	s contributing to	death but n	ot resulting in the	ne underlying	cause giv	ven in Part I.					the cause of death?
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ပိ	e law r has be	Completed		D8tre	ictive		reep	0	Dan	QA_	_	24a. Was a autops perform	sv	b. Were aut	topsy findings available completion of cause of
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on	ding th. After	tlon	1 Natural 2 Accident	5 🗌 Pending		e of Injury onth, Day Ye	e <i>ar)</i> Inju	ıry M		rk?]Yes 2□No					
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	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	cai (29a. Certifier (Check only	1 Certifying	Physician: To the	ne best of m	ny knowledge, o	death occurre	ed at the time	me, date and p	olace, and	due to the c	ause(s) and	manner as	stated. to the cause(s)
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				O un						D46979			112	1100	0
	RREI		_	dress of person wh					D 1	C	000	A T7 ~1 -		m 66	
4	Sta	te	31. Date filed (Mo		32.	Redistrar's		-		, suite	_203	A Wald	ori,	¥Ð 20€	0U2
	Registr			IAN 3	1 2006	Margar.	as H.	anne	11						

			- FOI	artment of Health and Ment rtificate of Death	tal Hygiene Reg. No. 006	03971
	Physici /Medio		1. Decedent's Name (First Middle, Last) EMMA COE	N.	Number 2 2, 2006	3. Time of Death 9:55 M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Hebrew Home 5. Social Security Number 6. Sex 1 M 20 F 94 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	Man	Month, Day, Year) Cou	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exacilitat matternatible notified at once.	To Be Completed by Funeral Director	Maryland Montgomery Silver 10e. Street and Number 3627 S. Leisure World Blvd 11. Marital Status 1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced 1 □ Yes 2 □ XNo 1 □ Yes 2 □ Xno 1 □ Xes 2 □ Xes	20906 Was Decedent of Hispanic Origin? (Specify Nit Yes, specify Cuban, Mexican, Puerto Rican 1 Tes 2 No Specify: Ident's Usual Occupation a kind of work done during most of working DO NOT use retired) kkeeper 18. Mother's Name (First Sarah Han: Sarah Han: Ing Address (Street and Number or Ruraf Rout) 7 Ardennes Ave, Rock Constition (Name of matory or other place) coln Crematory Jan 2. Name and Address of Facility Hines 1800 New Hampshire A	Specify: White White Item 16b. Kind of Business/I Public Util st. Middle, Maiden Sumame) igbaum ute Number, City or Town, State, Z ville, MD 20851 20c. Location - City or Town, State, Z 28, 2006 Brent Rinaldi Funeral ve, Silver Sprin	rican Indian, 5, etc. Ce Industry Lities Town, State Twood, MD L Home Ing, MD 20904
58760,	Physician bhysician and physician and street be physician and street street street by the prival transit	edical Examiner	resulting in death) Due to (or as a consequence of): ARTERIAL Sequentially list conditions	iter the mode of dying, such as cardiac or res ISS CULAR ACCIDE HYPERTENSION	ENT	Approximate Interval Between Onset and Death
P.O. Box (The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/M	In the past 12 menths? 1 Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the unit of the significant conditions.	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23d. Date of deli Month	Day Year
al Records,	aw requisible been 2 should	Completed by	DIABETES MELLITUS		24a. Was an autopsy performed?	topsy findings available completion of cause of
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 29a. Medicel Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier			to the cause(s)
	15		30. Name and address of person who completed cause of deeth (Mem 82a) (Type	Prior LLE MD 2	0852	
	St Regist	ate rar	31. Date filed (Month Day, Year) JAN 2 7 2006 32. Registrar's Signature	barle		

CPM 06-00606 Jose Contreres

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ı	Physici		Decedent's Name (First, Middle, Last Jose	Contre	cas			2. Date of Dea January		3. Time of Death 13:36 M				
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	with the factor as or 28a-	Direct	10e. Street and Number 2336 Glenmont S	Street Ant	- 6	10f. Zip Code	902		10g. Citizen of What Co	·				
9	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "netural", or items 23s or 28s-f ehow event, the Medical Exemplar roual be notified at	/ Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 XNo If Yes, Give		Was Decedent of	f Hispanic Origin? uban, Mexican, Pu		14. Race - Ame Black, Whit	erican Indian,				
21215-0036	in 72 hours n "netural", fedical Exe	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates: cation e completed)	(Giv	edent's Usual Occ	El Sal		16b. Kind of Business					
	e filed within all Hygiene. other then "		Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Tr	ash Dis	-	ame (First, Middle,		cycling Co				
Maryland	2 should be f and Mental P ie marked of raumatic eve	To Be	Victor Carpano		19b. Mai	ing Address (Stre	1.	icia Ri	Vas	Zin Code)				
	os 1 and of Health if item 27 r other t		Carlos Flores/E 20a. Method of Disposition 1 🛭 Burial 2 Cremation 3	Brother Removal from State	540 20b. Place of Disp cametery, cre	3 Joel	Lane Te		lls, Md. 20c. Location · City or Silver S	20748 Town, State				
Baltimore,	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) 21. Signature of uneral Service Licen	/ A.	ress of Facility D	I FUNER	AL SERVIC	E, P. A.						
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8760,	cate be executed physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co										
.O. Box 6	The law requires that the death certific te has been signed by the ettending p age 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of de Month	ivery Day Year				
rds, P	quires that en signed b uld be deta	٥	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying cause (given in Part I.	23e. Did to	obacco use contribute to ves 2 No 3 □ Po	o the cause of death?				
al Records,	Ø 1.T	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of				
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	lospital: 1 Inpatient	2 XER/Outpatie	nt 3□ DOA)ther	eath <i>Check only</i> of Home 5 Resid	<i>ne)</i> lence 6 ∏Other <i>(Spe</i>	cify)				
Division of	ding h. After tune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Ye 1/24/2006 28e. Place of Injury building, etc. (5	At home, farm, s	2 M 1	Yes 2 □ No	Subject 1	Street and Number or Ri	y trash truk ural Route Number, vidge Place				
J	Hospita 4 hours Funeral ely filled	edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	y knowledge, dea amination and/or i	th occurred at the	time, date and pla opinion, death oc	ce, and due to the courred at the time, of	cause(s) and manner as date and place, and due	s stated. to the cause(s)				
	To the within 2 To the complete	Me	29b. Signature and title of certifier Zabulla	SAL	5		nse number ME		January 25					
	1		30. Name and address of person who can ZABIUCEAH		(Item 23a) (Type	, Print) 111	Penn St	reet Bal	timore, Man	ryland 21201				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 7 2	32. Pigistrar's	Signature	berle								

			1 = For State Registre MEND#SperFH, 1/2	State of Mar				lealth an Death	d Mental I	lygier		6	03973
	Physic	ian	1. Decedent's Name (First, Middle, Last,						2. Date of Month		ay	Year	3. Time of Death
de.	/Medi		Hazel May Carı						Janua		5 20	06	3:00 A ^M
	Exami	ner	4a. Facility Name (If not institution, give	· ·		4b. City		Location of D	eath		c. County o		
		Ų.	Shady Grove Adver 5. Social Security Number 6. Security Number			If I lade	Roc	kville	lden a		Montg		
4	Funeral Director			M 2ME	(In yrs. last birthday)	Months			Hrs. 8. Date of (Month, July	25, 2	,1912 !912	9. Birthp Coun MA	lace (State or Foreign ttry)
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	cation						1	0d. Inside City Limits
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	th with the 23a or 28 ist be no	al Director	10e. Street and Number 216 Hutton Street			10f. Zij	p Code	2087	7	_	itizen of Wi		•
	ems .	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Dece	dent of Hi	spanic Origin?	? (Specify Yes or uerto Rican, etc.)	No-	14. Race		
5-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Exemple main the multified at	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes		Specify:	dento Alcan, etc.)		Specify:	, White,	_{etc.} Thite
15-(n 72 h natu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece		ork done d	lurina most of	working	16b.	Kind of Bus	iness/Inc	dustry
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ğ	Hygid other	Be C	17. Father's Name (First, Middle, Last)			10 mcm	arcı	18. Mother's	Name (First, Mid				
ılar	should be nd Mental marked o	To B	Frank W. Whalen					Ida M	1. Veno				
Mar	12 sh hand 7 is m rraum		19a. Informant's Name/Relationship (Type Frederick W. Carro						Rural Route Num				
Sre	S to I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, crer	sition (Nai	me of		Date	20c.	_ocation - C	ity or To	wn, State
Ē	permit. Pages Department of i Important: if it any injury or o		4 □ Donation 5 □ Other (Specify)		Ft. Hill			Ja	nuary 30 2006	Lyn	chbur	g, V	A
Ba	Depar Impor Inn in		21. Signature of Funeral Service License		i			s of Facility	DeVol Fu	ınera	1 Hom	е,	10 East
	<u> </u>		23a. Part1. Enter the disease, or compli						Gaithe		g, MD	208	77 Approximate
	Physician /Medical Examiner	ler	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		onsequence of):	dera		fa	· col	11+1			Interval Between Onset and Death
oʻ	death certificate be executed e attending physician and id for use as the burial-transit	Examine	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	1			(2/1/	eli				
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o,	che th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	dc. If yes, outcome of particles of the second seco	Fetal death 3	Ectopic pr Other (sp	regnancy secify)			_	23d. Date of Month		ry Day Year
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Division of Vital Records,	ine law requ	Completed							pe	topsy rformed?	prio	or to com ath?	sy findings available
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> ·	nysic nis ce direc	10	examiner?	spital: 1 Xnpatient	2 ER/Outpatien	3 DC	A Othe	-	gHome 5□Re	- 11	6 □Other	(Specify))
0 7	ng Pri fter th		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	2	8c. Injury Work		28d. Describ				<u>, </u>
20	Attending Projection: It death. ector: After this certifica by the funeral director.	catio	2 Accident investigation			М		es 2 □No					
ב ב	i Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory	, office		28f. Location City or 7	(Street a own, Stat	nd Number e)	or Rural	Route Number,
	within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Phys	cien: To the best of mer: On the basis of example and manner stated	amination and/or inv	occurred estigation,	at the time in my opi	e, date and pla inion, death oc	ice, and due to the courred at the tim	e, date an) and mann d place, and	er as sta d due to	ited. the cause(s)
	To the comp	¥	29b. Signature and title of certifier	2		290	License	number		29d. Da	ite signed (i	Month, D	lay, Year)
			MUNGANI	/		D	41	1628	ND	2	300	0 - 4	25 2006
	4		30. Name and ad ess of person who cor	apleted cause of death	n (Item 23a) (Type, F	Print)	, , ,	(-; -;	: 100 0 ~	lou	N E	20	
3	Sta	e	31. Date filed (Month, Day, Year)	32. Anistrar's	Signature	alle	106		(- 11 "	5 6	574
4	Registra		JAN 27 20	D6 America	J. An	aster)							

			T = For State Registrar	State of Mai		artment of H		nd Mental Hy	giene	5 03974
	Physici		1. Decedent's Name (First, Middle, Last)	COBU	۸١			2. Date of De Month	eath	Year 2.45A M
	/Medic Examir		4a. Facility Name (If not institution, give s		. 0	4b. City, Town, or	Location of		4c. County o	00
			Millennium Nursing	g Home		Ellicot			Howa	ard
Ē	Funeral		5. Social Security Number 6. Sex	M 2□ E	(In yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
	Director		236 32 6384 Usual Residence of Decedent	7	9			Aug 8,	1926	West Virginia
	ryland	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f	ecto	MD Howard		Ellico	tt City			40.00	1 ☐ Yes 2🛣 No
	with t	Funeral Director	10e. Street and Number 3013 Center Drive			10f. Zip Code 21042			10g. Citizen of WI	-
	death	nera		12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hi	spanic Origin	n? (Specify Yes or No	- 14. Race	- American Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Mudical Examinar must be notified at	by	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1		If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specify:	Puerto Hican, etc.)	Specify:	, White, etc. White
2-0	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done o	luring most o	of working	16b. Kind of Bus	
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		tant "stat		Ja = 1 =	T13 '	
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ılan	Aental Aental rked c	To Be	Eugeneous Earl Cok	oun			Grace	0'Haver		
Maryland	s 1 and 2 should be if Health and Mental itam 27 is marked other traumatic ev	,-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street a	and Number	or Rural Route Numb	er, City or Town, S	tate, Zip Code)
	l and lealth im 27 her ti		Wanita Cobun/Wife		3013 20b. Place of Dispe		rive E	Ellicott C:		21042 lity or Town, State
Jor	nt of h		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other place wn Mem. G		-28-2006		tsville, MD
Baltimore	permit. Pages i Department of H important: if ita any injury or ot once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	e 0 / M	<u></u>		1			amily FH Inc.
Ba	Dermi Depa impo any ir		Show Collins	wife	4	112 Old Co	olumbi	a Pike Ell	<u>licott Ci</u>	ty, MD 21043
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		er the mode of dying	g, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		consequence of):					
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	and and	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a c		HET EK	7 V	State		
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Ś	The law requires that the ate has been signed by the page 2 should be detache	by P	Part II Other significant conditions conf	tributing to death but	not resulting in the u	nderlying cause give	n in Part I.			ute to the cause of death?
ord	requir een si nould	ted	CHOCKE OF	1100	3117 6			101	Yes 2□No 3	Probably 4 Tunknown
Sec	has b	Completed						24a. Was autop	osy pric	ore autopsy findings available or to completion of cause of ath?
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying Physi (Check only 2 ☐ Medicel Exemin	icien: To the best of a	my knowledge, deat	n occurred at the time	e, date and p	place, and due to the	cause(s) and mann	per as stated.
	the h	Medicai	one) 29b. Signature and title of certifier	and manner state	d.	29c. License			29d. Date signed (
1	N N N		· IWA	cen/ U	49)	D539	787		et -	6 2006
/	,° ,	ŀ	30. Name and address of person who cor	npleted cause of deat	th (Item 23a) (Type,	Print) KEW	VETT	+ GEH	ZMD, C	
)	E.G.		300 BRWORY	Mr. Suit	£ 34 9	BALTIMO	RZ	NO 20	2010	
,	Sta Registra		31. Date filed (Month, Day, Year) , IAN 3 0 20		Signature	parte				

			1 - For State Registrar		State of M	1arylar		artmen rtificat			and M	F	leg. No.		03975
	Physici	an	1. Decedent's Name (First, Mic				-114	_				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	cal	Ronald 4a. Facility Name (If not institut	Le			olliso		Tour or	Location of		January		2006 ounty of Deat	0350 M
	Examir	ier	South River				ontor		ewat		Death			ie Arui	
	Funeral		5. Social Security Number	6. Sex			last birthday)	If Under	1 Year	If Under		8. Date of Birth)		hplace (State or Foreign untry)
	Director		216-40-1130	1 💢 !	M 2□F	63	Yrs.	Months	Days	Hours	Min.	(Month, Da) Aug. 10			ryland
	pu ,		Usual Residence of Decedent 10a. State 10b. Cour	ah.		10c Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	ehov	Į.			~		asonvi								1 □ Yes 2 □ No
	28a-f	Funeral Director	MD Queen 10e. Street and Number	Anne	5	GI	asonvi	10f. Zip	Code				10a. Citize	n of What Co	
	with 3a or	٥	2 A Fisher Ma	nor					638				USA		•
	death me 2;	era	11. Marital Status		. Was Deceden	t Ever in U	I.S. 13.			spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ame	
9	or Ita	교	1 Never Married 2 M	arned	Armed Forces 1 X Y es 2 [If Yes, Give			1 Yes, spen		n, mexican Specify:		rican, etc.)		Black, Whit	e, etc. White
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21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itame 23a or 28e-f ehow the Madical Exandiar must be motified at	Completed	15. Deced (Specify only high	ent's Educa hest grade	tion com <i>pleted)</i>		16a. Dece (Give	dent's Usua kind of wo DO NOT us	rk done a	luring mos	t of workir	ng	16b. Kind	of Business/	Industry
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d 2	Hygie other	BeC	17. Father's Name (First, Middle	le, Last)			darpe	IILCI		18. Mothe	er's Name	(First, Middle,			011
lan	ould be Mental Marked o	To B	Thomas Collis	son						Elea	anor	Leach			
Maryland	동절트특	ľ	19a. Informant's Name/Relatio	nship (Type	e, Print)		19b. Maili	ng Address	(Street a	ınd Numbe	er or Rura	l Route Numbe	r, City or T	own, State, 2	Zip Code)
Σ,	and and and and and and and and and and		Brenda Collis	son (D	aughter					nor,		onville			
ore	ges 1 t of H if Ite		20a. Method of Disposition 1 Burial 2 Crematio	n 3□Re	moval from Stat	9	Place of Dispo cemetery, crea	matory or o	ther place			ate		tion - City or	
Baltimore,	permit. Pages Department of Important: If I any Injury or one	,	4 Donation 5 Other			Me	tro Cr				L/28/			imore,	MD
Ba	permit. Pages 1 and 2 Department of Health ar Important: If Item 27 le any Injury or other tras		21. Signature of Funeral Service		11/1		24	Hard	esty	Fune	ral :	Home, P	.A.	MD 21	1401
	91		23a. Part 1. Enter the disease,	or complica	ations that cause	ed the dear	th. Do not en					• Annap		MD 2.	Approximate Interval Between
To	Physician		Immediate Cause (Final	ist only one	cause on each	T.	v M	To	i.L.	1126				The state of the s	Onset and Death
100	/Medical		disease or condition resulting in death)	a.	Due to (or a	s a consec	quence of):	\ f	<u> </u>	0/0				-	
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Вох	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	230	o. If yes, outcom			∃Ectopic pi					23	d. Date of dei	ivery
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Records,	w require been sign should t	Completed									_				
3ec	e taw has b	mpie										24a. Was a autop perfor	sy	24b. Were au prior to death?	topsy findings available completion of cause of
a			05.111									1 ☐ Yes	2 No	1 🗆 Yes	2 No
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o	ig Physical dispersion	7: To	27. Manner of Death		28a. Date of In (Month, D		28b. Time o		28c. Injury Work			28d. Describe h			on y /
io	별목속	atio	E _ //obligativ	stigation	(MOITH, L	ay rear)	Injury	М		res 2 🔲	No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be irmined	28e. Place of Inbuilding,	njury - At h		reet, factor	, office		2	28f. Location (S City or Tow	treet and I n, State)	Number or Ru	ıral Route Number,
	Hoepital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 Certifier (Check only 2 Medic	al Examine	cian: To the bes ir: On the basis and manners	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	ie, date an pinion, dea	id place, a th occurre	and due to the o ad at the time, o	ause(s) ar late and p	nd manner as ace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certi	field	and marrier			290	c. License	number			29d. Date	signed (Mont	h, Day, Year)
	- s + 0		► Chalas	E. V.	1-2			X	57	313	•		Ì	122	3/06
			30. Name and address of person	on who com	pleted cause of	death (Iter	п 23а) (Туре,	Print)) 1	101		25	0.7	- 1	
			MITUL DA	VZ	821	NNI	DEN	ME	- 1	arcl	(We	RE	212	-01	
	Sta Registr	-	JAN 2 6	200 6	Z. Hegis	trar's Signa	ature L	elle p							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:25 P M January 28, 2006 Ryon Duley, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 13805 Duley Station Road Upper Marlboro 8. Date of Birth (Month, Day, Yea June 23, 1 If Under 1 Year II Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Maryland 82 1923 Director 216-16-0130 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be restitled at 1 ☐ Yes 2 XNo Director Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13805 Duley Station Road 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Heelth and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Iten wy highry or other traumatic event, the Madical Exercinal BORS. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White φ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Farm Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Alton Duley Irene Elizabeth Downing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Joyce C. Duley-Wife 13805 Duley Station Road, Upper Marlboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method ol Disposition February 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Upper Marlboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Thomas Church Cem. 2006 22. Name and Address of Facility 21. Signaty ne of Funeral Service Licensee 3035 01d Washington Road M01391 POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physiclen and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence ol) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a Was an autopsy 2 1 No 1 🔲 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 🔀 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number en who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 040 GCC MI 31. Date liled (Month, Day, Year) 32. Agistrar's Signature State Registrar

		•	for State Registrar	State of Ma	_		rtment			ınd M	ental Hy	giene Reg. No.	0.0	5	039	77
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			State of Maryland / Department of Health and Mental Hygiene	
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Ī	Funeral Director		5. Social Security Number 6. Sex 1. M 2 F 49 Yrs. 6. Sex 49 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birth10-27-1956. Birthplac (Month, Day, Pear) (Month, Day, Pear) Oct 26 1956 Vietna	e (State or Foreign am
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28e-1 ahow any injury or other traumatic avant, the Medical Examiner must be notified.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 14. Race - American Black, White, etc. Specify: 1 Yes, Give Year or Dates:	3.
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Baltimore.	Pages 1 nent of H ant: if ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place)	
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	withii To th	Σ	29b. Signature and title of certifier Bichhum M. Pinh 29c. License number 29d. Date signed (Month, Deg.) Tanuary 95,	
	5		Bichhung M. Vinh V54996 January 25, 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Bichhuong M. Vinh 900 S. Caten Are, Box #60, Baltimore, M92	1229
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State of Maryland / Department of Health and Mental Hygiene U U 6

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, a ^M 2006 1:00 Geraldine Ramona Eaton January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Port Deposit Residence: 21 Abrahams Road 8. Date of Birth (Month, Day, Year) May 13, 1950 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) Maryland 1 □ M 2 🛛 F 55 Yrs 213-46-1867 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No Port Deposit Maryland Cecil Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21904 U.S.A. 21 Abrahams Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Aberdeen Proving Ground M Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen, Maryland Secretary Environmental Government Twelve Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 le marked ott Gerdine Robert Presnell, Sr. Helen Elizabeth Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 Abrahams Road, Port Deposit, Maryland 21904 Lawrence D. Eaton, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. West Nottingham Cemetery 02/01/06 Colora, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903 MICHALDEN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatie O vanan 20 months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as ed by the attending detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2X No 2 🗌 No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Tes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? 27 Manner of Death Certification: After Injury 1 X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 131 0 llman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 2200, BALTIMORE, MD 10 DRIVE 910 TRANKLIN KAO 3 31. Date filed (Month, Day, Year) JAN 3 1 2006 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fth 19852 2-15-06 vt. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 501 007 31 2006 4c. County of Death Richard Paul Franke 06:25 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Legional medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last b If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. WICOMICO 8. Date of Birth Birthplace (State or Foreign Country)
 Indiana 7. Age (In yrs. last birthday) **Funeral** Months 1 **30**M 2 □ F Yrs. Director 219-16-7721 (3/31/1925 80 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State rthen "natural", or items 23s or 28s-f ehow the Medical Examinar must be notified at 1 TYes 2 XNo Director Ocean Pines Worcester 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code filed within 72 hours after death with USA 10 Morning Mist Dr. 21811 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1√2 Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White δ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Engineering Engineer permit. Pages 1 end 2 should be filed w Depertment of Heelth and Mental Hygier Importent: if Itam 27 is marked other th any Injury or other traumatic event, ITagone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Heckman Edwin Arthur Franke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Morning Mist Dr., Ocean Pines, MD 21811 Betty E. Franke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 1/31/06 Frankford, DE 4 Donation 5 Other (Specify) 21. Signature of Fune ervice Licensee 22. Name and Address of Facility The Burbage Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mctastatic Transitional Cell Carcino-a Physician 370009 7 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 Ischenic Heart Digeose 1 Yes 2 XNo 3 Probably 4 Unknown Be Completed Diobetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 | Yes 2 | X No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 prinpatient 2 ER/Outpatient 3 00A Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No death. 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide t 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030690 11,0, 30. N e and address of rerson who completed cause of death (Item 23a) (Type, Print)

State Registrar

FEB 0 1 2006 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

H. MARTIN M.D. 175 E. Carroll St. Solisbury MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician 9:32 JANUARY 23, 2006 Α CLYDE DOUGLAS FRAME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY SILVER SPRING 13313 BANBURY PLACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/25/1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours NEW YORK 1₽M 2□F 77 Yrs. 016-24-5175 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show your to other treumatic event, fra Modical Examinar must be notified at once. 1 ☐ Yes 2 No Director MARYLAND SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 USA 13313 BANBURY PLACE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ă No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE 5+ MORTGAGE BANKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NELLIE MARGARET DREW WILLIAM FULTON FRAME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13313 BANBURY PLACE; SILVER SPRING MD 20904 JEAN FRAME - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FORT LINCOLN CREMATORY 1/27/2006 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licenses 11800 NEW HAMPSHIRE AVENUE; SILVER SPRING MD 20904 Myelin T. Klober 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** L.ver CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit been signed by the attending physicien end should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funarel Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 24, 2006 D39190 Janus 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH REILLY M.D. 3418 OLANWOOD COURT SUITE 111; OLNEY MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2006

32 Registrar's Signature

		ŀ	For State Registrar	State of Ma	aryland	•	artment of F				iene 06	03	3982
	*		Decedent's Name (First, Middle, Last)						. Date of Deat	h		t. Time of Death
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	Funeral		5. Social Security Number 6. Se	x 7. Ag		ast birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs. 8	. Date of Birth (Month, Day,	9		State or Foreign
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	with t	2	10e. Street and Number				21801			,	USA	Country	
	within 72 hours after deeth with the Maryland ane. then "naturel", or Iteme 23a or 28a-f show ha Medical Exarch at most Le codified at	Funeral Director	611 Tressler Dr.	12. Was Decedent	Ever in 11	S 13 1	Was Decedent of H	lispanic (Origin? (Speci	fv Yes or No-	14. Race - A	American I	Indian.
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ore	ges 1 end 2 should t of Health and Mer if Item 27 ie marke or other treumatic		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐	Removal from State			sition (Name of natory or other pla		1		20c. Location - City		
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Baltimore, Maryland 21215-0036	permit. Pages 1 en Department of Heal Important: If Item 2 eny Injury or other once.		21. Synature of Funeral Service Lights			ff 5	olloway Ol Snow I	fune Hill	Rd. Sa	me P.A. alisbur	y, Maryla	ınd 2	1804
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387	death certificate be executed e attending physician and of for use as the burial-transit	dical	•	d									
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pat y	Sta		31. Date filed (Month, Day, Year)		rar's Signa	4.1	A .						
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			For State Registrar	State of	Maryland		artment			and M		giene	006	03	983
	14,		Decedent's Name (First, Middle,	Last)							2. Date of De	ath		3. Time	of Death
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	/Medio Examín		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death		4c. 0	County of Dea	th	
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	Funeral Director		5. Social Security Number 212-19-2197	6. Sex 1 □ M 2 🗹 F	7. Age (In yrs. la 20	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 06/09/	1985	9. Bir Co Maj	thplace (State puntry) Lne	e or Foreign
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Ma	ith an		John Gilkerson/								ie, MD				
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	Sta Registr		31. Date filed (Month, Day, Year) JAN 2	5 2006	Gara's Signat	K	Charle	E.							

DHMH 17 Rev 1/200

Registrar

			1 - For State Registrar	State of M	aryland				lealth a D <i>eath</i>	nd Me	-	giene Reg. No.	IIIIb	039	85
	(C		1. Decedent's Name (First, Middle, La	st)				_			2. Date of De.	Day	/ Yea	3. Time o	f Death
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	Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City	, Town, or	Location of	Death		4c.	County of De	ath	
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	Funeral Director		5. Social Security Number 6. S 220-22-0187	M 2 X 2X	9 (in yrs. ia 9 4	ast birthday) Yrs.	Monihs		Hours	Min.	B. Date of Bird (Month, Da	y, Year)	1911	irthplace (State Country) Maryla	
¥			Usual Residence of Decedent								Aug.	14,	1911	патут	and
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	item item	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯			was Dec	ecify Cuba	ispanic Orig in, Mexican,	nn? (Speci , Puerto Ri	ify Yes or No ican, etc.)	-	Black, Wh	nerican Indian, nite, etc.	
36	or, or	by Funerai	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140		1 Tes	2000	Specify:				Specify:	Black	
ğ	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow he Madical Examiner must be notified at	Completed	15. Decedent's E			16a. Dece	dent's Us	uai Occupa	ation furing most	of working		16b. K	ind of Busines	s/industry	
2	thin 7	npie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired)	or working			Howard		
7	ed wi		8th				Cas.	hier			(F)			School	
ind	be fill htal H d oth	Be	17. Father's Name (First, Middle, Last,						18. Mother		First, Middle, Hens		Sumame)		
2	d Mer d Mer mark	٩	John Car 19a. Informant's Name/Relationship (10b Mailie	an Addroi	e (Stmat	and Number				r Town, State	Zin Code)	
Maryland 21215-0036	id 2 s ith an 27 io trau		Jeanette Powe		htar'									MD 21	146
ē,	Hean Hean		20a. Method of Disposition	II (Baag	20b. Pla	ace of Dispo	sition (Na	me of	I	Da				or Town, State	710
ě	and in the second		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ilfor				2/4	/06	Co	lumbia	a, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show any fujurg or other traumatic event, the Madical Examiner must be notified at once.		21 Signature of Funeral Service Licer		1/2	22	2. Name a	and Addres	ss of Facility	SNO	WDEN	FUN	ERAL I	HOME, I	P.A.
m	80E 8		800ge 1.1	1/1000	XU	1 2	46	v. W	ash.	St.	, Roc	kvi.	lle, 1	4D 2085	50
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. ine.	. Do not ent	er the mo	de of dyin	g, such as c	cardiac or	respiratory ai	rrest,		Approxima Interval Be	tween
>	Physician		Immediate Cause (Final disease or condition	a Ce	rebra	al Th	rom	bosi	s					Onset and Minu	
	/Medical Examiner		resulting in death)	Due to (or as				0001							
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequi	ence of):									
	ted nsit	Examine	Cause (Disease or injury	500 10 (01 23	a 501130qa	01100 017.									
<u>_</u> ,	execunand nand ial-tra	Exar	that initiated events resulting in death) Last	C. Due lo (or as	a consequ	ence oi):					·······				
8760,	cate be executed physician and the burial-transit	dicail	(_d											
9	ng ph as th	Medi	IE EE WAS						<u> </u>						
Вох	death certifica attending ph d for use as ti	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			Ectopic	pregnancy					23d. Date of d Month		Year
O.	the at	Physician/Med	1 Yes 2 No 9 Unknown	4□Pregnant a 9□ Unknown	t time of de	ath 5	Other (pecify)			-		WOM	Duy	roui
۵.	that the death cert ed by the attendin detached for use		Part II. Other significant conditions of	contributing to death b	out not resul	lting in the u	nderlvina	cause give	en in Part I.		23e. Did t	obacco u	ise contribute	to the cause of	death?
ds,	9 G	d by		•		3	, ,	•			10	res 2	№ No 3 🗆	Probably 4 🗆	Unknown
Sor	w requir been si should	Completed									24a. Was	an	24b Were	autopsy findings	available
æ	ysicien: The lav is certificate has director, page 2	g E									autop	rmed?	prior to death	completion of (cause of
ta		0	25. Was case relerred to medical						26. Place	of Death /	Check only of	2 <mark>∑</mark> No ne)	1011	s 2□ No	
\leq	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 2	R/Outpatier	nt 3 🗆 🖸	Othe	25				6 □Other (Sp	ecify)	
0	Attending Physicien: r death. ector: After this certific by the funeral director,	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry y Year)	28b. Time o Injury	f	28c. Injun Work	/ at c?	28	d. Describe l	now injur	y occurred		
Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not b				М		Yes 2□N						
Division of Vital Record	after d Direct In by	Certification:	4 Homicide determined	286. Place of in	jury - At hor tc. <i>(Specify)</i>	me, farm, st	eet, facto	ry, office		28	If. Location (3 City or Tox			Ru <i>ral R</i> oute Nun	n <i>ber</i> ,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	I Ce	29a. Certifier 1 ★ Certifying Pf	ysician: To the best	of my know	viedne deat	h occurre	d at the tim	ne date and	d place an	nd due to the	Callee/c)	and manner	as stated	
	24 hos Eur	edical		miner: On the basis of and manner st	f examinati	on and/or in	vestigatio	n, in my o	pinion, deat	h occurred	d at the time,	dale and	place, and d	ue to the cause(S)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	1	_		2	9c. License	e number	_		29d. Da	te signed (Mo	nth, Dey, Year)	
•	5		William	~ M W	an	eny	4).	1	391	16		Ja	n. 27	, 2006	
	,		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)								
			William A. 31. Dale filed (Month, Day, Year)	Warren,	M.D.	321	Pr	ince	Geoi	rges	St.,	La	urel,	MD 20	707
100	Sta Registi			2006	LARA S	J. 19	100								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** BARBARA V. HIGGINS JANUARY 2006 30 2:15AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCT 6, 1938 Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K Months Days Hours 67 214-36-7298 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel; or Iteme 23a or 28e-f show any injury or other treumatic event. If a Mydical Exacting mast kernollified any injury or other treumatic event. It as Mydical Exacting mast kernollified and 1 Yes XX No Director ST. MICHAELS TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA #28 SWAN VILLA 21663 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: þ Specify WHITE. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 OWNER RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT A. COOPER, SR. CLARA BIEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWARD H. HIGGINS, JR./SON 9722 TILGHMAN ISLAND RD., MCDANIEL, MD 21647 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR.1/31/2006 STEVENSVILLE, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph M. Ostro-Shi C.G. 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 mm Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, fany, facing of infractions, cause. Enter Underlying Cause (Disease or injury that initiated events Dire to for an a ponsecuence of: Examine the attending physician and hed for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown s been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No ၉ 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funerel Dire To the Hospitel 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 428 GL 30. Name and address of person o comilete cause of death (Item 23a) (Type, Print) provid 555 EASOUN MO RA SMERONI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

JAN 3 1 2006

			1 - For State Registrar	State of I	Marylar				lealth a	and Mo	_	giene Reg. No:	IIII	03988
1	Dh. air		1. Decedent's Name (First, Middle, La	st)							2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Robert Thomas Han	non							Januar		2006	11:00 AM
1	Examin		4a. Facility Name (If not institution, give	e street and numb	er)		4b. City,	Town, or	Location o	f Death		4c.	County of Death	
	· / /	9 - · ·	100 Huse Drive				14 1 (0 d 0		Annap				Anne A	
	Funeral Director		213-22-1538	M a⊟ E	Age (In yrs.	/ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan. 3(y, Year)	9. Birth Co.	nplace (State or Foreign untry) ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary -f sho	tor	Maryland Anne Ar	undel		Anna	apoli	5						1 ☐ Yes 2 🛣 No
	r 28a	Irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Co	untry?
	7 with	Funeral Director	100 Huse Drive				214	03			1	Jnite	d State	85
	em.	iner	11. Marital Status	12. Was Decede	s?		Was Dece	dent of Hi	ispanic Orig	gin? (Sper	cify Yes or No Rican, etc.)	- 1	14. Race - Amer Black, White	
36	be filed within 72 hours after deeth with the Maryland stal Hygiene. d other than "naturel", or Iteme 23a or 28a-f show event, I're Medical Exerting right be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XX es 2	□ No 19	44-	1 🗆 Yes		Specify:		,	-	Specify: Wh	- 10
8	ture!	ed b	15. Decedent's E	Year or Date	s: 19	16a. Dece	dent's lisu	al Occupa	ation			16b Kir	nd of Business/l	ndustry
7.	n "na	plet	(Specify only highest gro	ade completed)		(Give	kind of wo	rk done d se retired	during most	of workin	g	100. 11	id of Dasinosar	nousily
21215-0036	d within giene. or than "	Completed	Elementary/Secondary (0-12)	College (1-4	015+)		Brick	1aye	r				Constru	ction
멀	be filed tal Hygid d other event, I	36	17. Father's Name (First, Middle, Last)							(First, Middle,			
<u>Na</u>	should by and Menta marked matic e	To	Harold Leo Hannon						Cathe	reri	ne Kell	iher	•	
Maryland	nd 2 sho alth and 27 is m or traum		19a. Informant's Name/Relationship (Herbert Hannon /										Town, State, Z 1 21401	iip Code)
ore,	of He of He r oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	TRamousi from Sta	1 ,	Place of Dispo	natory or o	me of other place	θ)	Da	ate	20c. Lo	cation - City or	Fown, State
Ë	Page ment ant: fi ury o		4 □Donation 5 □ Other (Special	(y) 0 1	Bal	timore			,					iary land
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic espace.		in Signal are of Funeral Service Vo	In the										Home, Inc , MD 21401
8760,	death certificate be executed Wedical Examine and physician and for use as the burial transit	Ical Examiner	shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Meta. Due to (or Due to (or c.	as a consequence as a c	quence of):	lign	si v?	+ an	rela	\$10 i V?	9		Interval Between Onset and Death I 7 mo S
P.O. Box 68	death certific e attending p ed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1□Live birth 4□Pregnan 9□Unknown	1 2 □ Feta tat time of c	al déath 3	Ectopic p					2	3d. Date of deli Month	very Day Year
	juires that the n signed by th ild be detache	ρ	Part II. Dther significant conditions of	contributing to deat	h but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did t			the cause of death?
Records,	The law requires sete hes been sign page 2 should be	Completed				·					24a. Was autor pendo 1 🗆 Yes		24b. Were au prior to c death?	topsy findings available completion of cause of
ta	yeiclan: Th is certificete director, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	/-		
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ion c	Attending P or death. ctor: After the funeral by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	M	28c. Injury Work 1 🔲 `	rat ∢? Yes 2.⊟N	- 1	8d. Desčribe i	now injury	occurred	
Division of Vital	257	Certification:	3 Suicide 6 Could not be determined	200. Flace 01	Injury - At heetc. (Special	ome, farm, str	eet, factor	y, office		2	8f. Location (: City or Tou			ra! Route Number,
	the Hospital of thin 24 hours at the Funeral Dimbletely filled in	edlcal	29a. Certifier 1 Certifying Pt (Check only one) 2 Madical Exam	nysician: To the be niner: On the basis and manner	s of examina	owledge, death ation and/or in	occurred vestigation	at the tim	ne, date and pinion, deat	d place, a th occurre	nd due to the od at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	4 .	^			c. License					signed (Monti	
)			1 ll- Cenn	un Mi			1	00 E	591:	73		ĺ	-26-	2006
			30. Name and address of person who KATIHLEEN KE	completed cause of	of death (Iter	n 23a) (Type,	Print)	ATE	RD	#30	OU ANI	VAPO	ous m	2006
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature	mark	,	•					*

			1 - For State Registrar	State o	f Maryla	nd / Depa	artment rtificate	of He	ealth a		ental Hy	jiene	006	039	89
			Decedent's Name (First, Middle	, Last)			mouto		704111		2. Date of Dea			3. Time o	f Death
	Physici		April		Hass	1 1					Month January	Day 26,	Year 2006	1:45	, M
	/Medio Examir		4a. Fecility Name (If not institution	give street and nu		se11	4b. City, To	own, or	Location of		January		County of Dea		_A
	Examir	er	145 Watkins Mi				Gait						ntgome		
-	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birtl			rthplace (State Country)	or Foreign
	Director		119-44-7599	1 □ M 2 ∑ F	52	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day Feb. 2	2^{rear}	953 Ne	ew York	
	ը .		Usual Residence of Decedent		140										
	anylau shov	Ē	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	ity Limits 2 1 No
	Ba-f	ectc	Maryland Montg	omery	Ga	aithers						10 0'''			
	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show hadical Exercinal reval be notiliad at	Funeral Director	10e. Street and Number 145 Watkins Mi	ll Road,	#1A		10f. Zip C	2087	9			-	ten of What C Lted St		
	ems erms	ıner	11. Marital Status	12. Was Dec	edent Ever in lorces?	U.S. 13.	Was Decede	nt of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh	nerican Indian, lite, etc.	
9	or it	y Fu	1 Never Married 2 Marri	If Yes, Gir	ve		1□ Yes 2		Specify:				Coocife:		
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7	"nat	lete	15. Decedent (Specify only highes			16a. Dece	dent's Usual kind of work DO NOT use	done di	tion u <i>ring m</i> osi	t of workin	g	16b. Kir	nd of Busines:	s/Industry	
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2	Hygie ther int, I		17. Father's Name (First, Middle, I		<u>-</u>	Teaci	ici s i			er's Name	(First, Middle,			CHECL	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show among injury or other traumatic event, It a Medical Examinat must be notified at once.		19a. Informant's Name/Relationsh Cherlun Kindrel		er						Route Number, Germ	_			
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₽	it. Purtine prism ortani		*4 □Donation 5 □ Other (S) 21. Signature of Funeral Service	#_/	C	remator	ium, I	nc.	s of Facilit	20	06 /ol Fun			a, Virgi	ınıa
Ba	permit Depar Impor any In		Att.	11/	M006									g, MD 2	0877
	_		23a. Part1. Enter the disease, or	complications that of	caused the dea								CIBBUL		
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	iician: The I certificate ha rector, page										1 ☐ Yes		1 ☐ Ye	s 2 No	
Vital	ician certif ector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Chack only o				
o	iding Physician: th. : After this certifice funeral director, i	. To	1 24 Yes 2 No 27. Manner of Death	1 . 1		ER/Outpatier 28b. Time o		1	4 🗀 140		ne 5 XResid 8d. Describe h			ecify)	
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É	in the	Certification;	4 Homicide determine	ned build	ing, etc. (Spec	city)	eer, ractory,	OHICE			City or Ton			18/2/110010 /10/	,50,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 1 € Certifyin	g Physician: To the	hest of my br	nowledne dest	h occurred of	t the tim	e date an	nd place 3	nd due to the	auso/e)	and manner	as stated	
	Hos 24 hc Fun stely	Medical		Examiner: On the b											5)
	ithin o the	Me	29b. Signature and title of certifier	0 1	\		29c.	License	number			29d. Date	signed (Mor	nth, Day, Year)	
)	- s + ō		1 long	The	In	2		04	42	35		1	26/0	56	
			30. Name and address of person	Mho completed call	se of death (Its	om 2 11 Type	Print)					. [30877
	5			VWANKW	P		120 A	RED	Fac	CL R	D #427	GA	THAISE	uph Wi	2
	Sta	te	31. Date filed (Month, Day, Year)	32. F	agistrar's Sigr	nature									
	Registi		JAN 2	7 2006 A	agua.	B. A	nade								

Donald Holloman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00595 State of Maryland / Department of Health and Mental Hygiene CTCertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 23 DONALD HOLLOMAN SR. January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□F 238-86-8913 Director Apr. 29, 1952 Carolina N. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow the Medical Examiner must be notified at Director 1 XYes 2 No MD Montgomery Montgomery Village 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 19058 Mills Choice Rd., #2 20886 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 No
If Yes, Give Year or Dates: 73- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiane. Important: If Itam 27 is marked other than "natural", or its any finitry or other traumatic avent. Its Medical Examina 2006. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 73-75 þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIST Supt of Janitorial Serv. l yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Paige Garris Ernest Holloman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) 19058 Mills Choice Rd, #2, Montg. Village, Theresa Holloman (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Ahoskie Family Cem 4 Donation 5 Dother (Specify) 1/29/06 Ahoskie, NC 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence f): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as tha burial-O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) I□Yes 2□No 9☐ Unknown 9 Unknown Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 \(\text{\text{Nursing Home}} \) 5 \(\text{\text{Residence}} \) 6 \(\text{\text{Other}} \) Other (Specify) 1 Yes 2 No 20XER/Outpatient 3 DOA 28d. Describe how injury occurred driver in mater After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) Certification; 1 Natural
2 Accident
3 Suicide 5 Pending 10:40 PM 1 Yes 2 No death. investigation venicle collision after death | Diractor: / d in by the f 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) N 270 Sprir Near Vemb-- At home, farm, street, factory, office 28e. Place of Injury 4 Thomicide street within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XPMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

arrella

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

OCME

January 24, 2006

who completed cause of death (Item 23a) (Type, Print)

Southail mi

III Pern Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) JAN 27 2006 32. Projistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State
Registra/AMEND#7, 8perFH1/27/06, BMW, McCo Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 22, 2006 10:15p Marina Hakspiel January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8774 Doves Fly Way Howard Laurel Hours Min. B. Date of Birth Hours Min. P. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√2 F Director Colombia, S.A. 215 62 3632 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortent: It tiem 27 ts marked other than "natural", or Iteme 23s or 28s-f show injury of other traumatic event, the Medical Examination must be notified at s. . 1 ☐ Yes 2 No Director Maryland Howard Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 8774 Doves Fly Way 20723 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural; or Iten any injury as after traumatic event, the Mudical Exercised once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Colombia Specify: White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carlina 2 Parra Arenas Roberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4414 Olando Lane Bowie, Maryland Vicente Hakspiel / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Maryland National Cem 1/26/2006 Laurel, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Sani 11800 New Hampshire Ave Silver Spring, MD 20904 2/a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Weeks Physician Stroke /Medical Due to (or as a consequence of): Examiner 40 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed? Yes 211No 1 Yes Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes ŽXNo 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19400 January 25, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 344 University Blvd. West Silver Spring, MD 20901 Ernesto Africano, M.D. State 2006 Registrar

		•	For State Registrar	State o	f Maryland		artment rtificate					iene	16	039	92
			Decedent's Name (First, Middle	e, Last)							2. Date of Death	Day	Year	3. Time of	
	Physici /Medic		Elzen	I.		Haw]	Ley				January	- · -	2006	7:45	a ^M
	Examin		4a. Facility Name (If not institution	n, give street and nu	m <i>ber)</i>		4b. City,	Town, or	Location of	of Death		4c. County	of Death		
			514 Kansala D				Anna			04 11-0		Anne	Arui		F
L	Funeral		5. Social Security Number	6. Sex 1 □ M 2 X F	7. Age (In yrs. la 98	st birthday) Yrs.	If Under Months	Days	Hours Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cour	lace (State of	
	Director		059-34-3639 Usual Residence of Decedent		70						Dec. 10	, 1907	reim	sylvan	Ia
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside Cit	•
	Man a-f sh	ţ	MD Anne	Arundel		Annap	olis							1 🗌 Yes	₹ XNo
	th the	irec	10e. Street and Number				10f. Zip	Code			11	og. Citizen of	What Cour	ntry?	
	23e c	al	514 Kansala D	rive					401				JSA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examination is solilled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 WWidowed 4 Divorced	Armed Fo	Z∕X No ve		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican S <i>pecify:</i>		cify Yes or No- Rican, etc.)		ce - Americ ck, White, y: Wh:	etc.	
Baltimore, Maryland 21215-0036	2 hou	ted	15. Deceden	t's Education		16a. Deced	lent's Usua	Occupa	ition			16b. Kind of B	usiness/In	dustry	
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<u>ya</u>	Ment Ment arkec	2	Walter Scott H								iffende				
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ď	l and Health Im 27 Iher 1		Faith Hawley H	owarth (Da		D14 ace of Dispo			Drive		napolis	20c. Location		own State	
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of only one cause on e	aused the death. each line.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Con	restin	1c /	ear		Fail	une					
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	A								. 51.6	
	_xammor	-	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseque		VOS	215						9 99	7
	ted nsit	Examiner	Cause (Disease or injury	<	(01 20 0 00 0000										
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9	ificate g phy as the	edic													
D. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live b	tcome of pregnan- birth 2 Petal of nant at time of dea own	leath 3	Ectopic pre Other (spe						ite of delive onth	,	⁄ear
Р. О.	hat the		Part II. Other significant condition	ons contributing to d	eath but not result	ting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use con	tribute to t	ne cause of d	leath?
Division of Vital Records,	signe d be	d by	Osteopor	_			, ,				1 □ Ye	s 2 (X)No	3 🗆 Prob	ably 4 🗆	Jnknown
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a	in: Ti	e C	25. Was case relerred to medical						26 Place	of Death	(Check only one	7	1 🗌 Yes	2 NO	
>	/sicle s cert direct	To B	examiner? 1 ☐ Yes 2 ☑No	Hospital	Inpatient 2 E	R/Outpatien	t 3 DO	A Othe			ne 5 Aeside		ner (Specif	y)	
0	g Phy er thi		27. Manner of Death	28a. Date	of Injury 2 th, Day Year)	28b. Time of Injury	28	Bc. Injury Work	at	2	28d. Describe ho	w injury occur	red		
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<u> </u>	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could and determined		of Injury - At homing, etc. (Specify)	ne, farm, str	eet, lactory	office		2	28f. Location (Str City or Town		ber or Rura	I Route Num	ber,
	itel or A														
	To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai		g Physician: To the Examiner: On the b and man											i)
	To the vithin To the comple	M	29b. Signature and title of certifie		. 0		29c.	License	number		29	d. Date signe	d (Month,	Day, Year)	
			I /on to	Some	- MD			DI	852	19-1	40	01-	24-	06	
			30. Name and address of person	who completed caus	se of death (Item 2	23a) (Type, EWAT	Print)	olon	ry D	R.	Annon	lis, A	(D) =	21401	
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signatu	ire	mode	0	J P	1-		7			

			1- State of Maryland / Item 26 per Dr., G855,	0570	rtment of F	lealth and Death	Mental Hy	giene Reg. No.	006	039	93
1	7.574 **S. 6.58		Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of	f Death
	Physici /Medio		Beatrice Held Johnson				01/17/	2006	Year	9:00	РМ
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of De	ath	4c. C	County of Death		
	S.,	3	Larkin Chase Nursing Home		Bowie			Pri	ine Geor	ges	
45.	Funeral Director		470-20-4916	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)	Cour	place (State on htry) Lesota	or Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Loc	cation				1	0d. Inside Ci	ity Limits
	Mary f sho	to	Maryland Prince Georges Bowie							1 X XYes	•
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Cour	ntry?	
	th with	a D	2623 Kennison Lane		20715			USA			
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	. 14	4. Race - Americ		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "natural", or items 23e or 28e-1 show event, "ite Medical Examinat must be rotified at	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:	and rican, etc.)	1	Black, White, Specify: Whi		
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup			16b. Kind	d of Business/Inc		
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and	be fill	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden S	lumame)		
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Ma	d 2 s th an th an 17 is i						Rural Route Numbe napolis,]			Code)	
	Heal Heal tem 2		20a. Method of Disposition 20b. Place of	Dispos	ition (Name of	1	Date Date		ation - City or To	wn. State	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic events.		1XXburial 2 □ Cremation 3 □ Removal from State Ma 4 □ Donation 5 □ Other (Specify) Vator	y, crem ryl:	atory or other place	:e) :- 01.4	24/2006				
alti.	mit. F partm oortar injui		21. Signature of Funeral Service Licensee		Cemeters Name and Address	ss of Facility R	bert E. 1	Snelt Evans	ennam Funera	MD 1 Home	د
m	Depa Impo any ii		Weel. Sheet				Road Bowi				
	Physician		29a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		r the mode of dyin	g, such as cardi		rest,		Approximate Interval Betw Onset and D	ween
	/Medical		resulting in death) Due to (or as a consequence of	of):	<i>₹′ /</i> '≠	0 7 0	7 (17) (1)				
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	ed isit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J1):							
	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence or	of):							
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Vital Records,	The law requ	Completed					24a. Was a autop perfor	sv /	24b. Were autop prior to cor death?		available ause of
ita	i ician : Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of D	eath Check only or				
<u></u>	Physic this or al dire	၉	1 Yes 2 Hospital: 1 Inpatient 2 ER/Ou		3□ DOA Othe	4 Lauvursing	Home 3 Resid	ence 6[□Other (Specify)	10.1
no On	ding F	ii o	X	ime of njury	28c. Injury Work		28d. Describe h	ow injury o	occurred		
isi	Attending Physician: r death. ector: After this certific by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No	204 Lanatina (C	44			
Division of	Hospital or Attend 24 hours after deatl Funeral Director: stely filled in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, fail building, etc. (Specify)	m, stre	et, factory, office		28f. Location (S City or Tow	n, State)	Number or Hura.	Houte Numb	<i>⊃</i> 8 <i>r</i> ,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 rifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death Dor inve	occurred at the timestigation, in my op	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	ause(s) ar late and pl	nd manner as st lace, and due to	ated. the cause(s))
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License	number	2	9d. Date s	signed (Month, I	Dey, Year)	
			· (Var ~) (y y)		1/2	6/90		1/	19/0	5	
_			30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)	Coyl.	Dive	Bu	Je 1	72 20	2
**************************************	Sta Registra		JAN 2 5 2006		Carles						

			1 - For Amend #26	State of Ma per/fh 01-	arylar -31-2	nd / Depa 2006 (2)	artmer Mificat	nt of H	ealth a Death	ind Me		giene Reg. No.	006	0399	94
			1. Decedent's Name (First, Middle, Las							1 2	2. Date of De			3. Time of C	Death
Н	Physici		Nathan	Johnson							Month Januar	y 26	2006	3:05	РМ
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of				County of Death		
	LAGITIT		Kline Hospice Hou	ıse			Мо	ount	Airy			Fre	derick		
-	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs.	last birthday)		r 1 Year	If Under 2		B. Date of Bir	th Variable	9. Birthp	olace (State or	Foreign
	Director		402-48-4225	M 2□F	71	Yrs.	Months	Days	Hours	Min.	(Month, Da eb. 26		34 Keni	tucky	
	D		Usual Residence of Decedent									,			
	rylar	_	10a. State 10b. County			ty, Town or Lo							[1	0d. Inside City	
	Ba-f.	Funeral Directo	Maryland Frederi	ck	Nev	w Marke	et							1 🙀 Yes	2 No
	or 26	Sire	10e. Street and Number				10f. Zij	Code				10g. Citiz	en of What Cour	ntry?	
	23a	a	181 Dorchester Dr	ive			2	1774				Un	ited Sta	ates	
	de i	ne	11. Marital Status	12. Was Decedent in Armed Forces?	Ever in U	.S. 13.	Was Dece	dent of Hi	ispanic Orig n, Mexican,	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)	- 1	 Race - Americ Black, White, 		
36	or it	by Fu	1 Never Married 2 Marned	1 ⊠Yes 2 ☐ N If Yes, Give			1 🗆 Yes	2 √ No	Specify:				Specify: Whi		
8	72 hours after death with the Maryland naturel', or Itema 23a or 28a-f show dical Examinan must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:	195	1									
쭈	"nat	Completed	15. Decedent's Ed (Specify only highest grad	le completed)	-	16a. Dece	dent's Usu kind of wo DO NOT u	ork done d	furing most	of working	7	16b. Kin	d of Business/In	dustry	
12	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	_			/			0	m .		
20	e filed within al Hygiene. I other than ' vent, It e Me		17. Father's Name (First, Middle, Last)			Entre	rene	ur	18. Mother	r's Name /	First, Middle,		Busines	SS	
an	od be	Be c	Sam Johnson						Jina l				,		
2	should be ind Mental I	ဥ	19a. Informant's Name/Relationship (T	voe Print)		19b. Mailir	ng Address					er City or	Town, State, Zip	(Code)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I health and marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		Nicholas Johnson			11	-				1d, PA			, 0000)	
a)	1 an Heal Heal		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer			1.00				ation - City or To	own, State	
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 eny Injury or other		1 Burial 2 Cremation 3 1								te 28,				1
늘	artme ortan injury		4 Donation 5 Other (Specify) Resthaven Crematory 2006 Frederick, Marganature of Fund al Service Licensee 21. Signature of Fund al Service Licensee Resthaven Fund Address of Facility Resthaven Fund Services, Skkot Cody												1
Ba	Depa Impo eny ir		1/11												
		9501 Catoctin Mtn. Hwy. Frederick, MD													
			23a. Part Enter the disease, a some shock, or heart failure. List only of Immediate Cause (Final		10.		01 010 1110	30 01 Gy 11 1	g, 545/145 t		ospiiatory a	,,		Approximate Interval Betw Onset and De	reen
	Physician /Medical		disease or condition resulting in death)	a	· - 1	-								12 0	273
	Examiner			Due to (or as	a conseq	uence of):									
		-	Sequentially list conditions,	b. Due to (or as	a conseq	uence of):									
	nsit	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,									
	be executed icien and burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or as	a conseq	uence of):									
8760,	ate be executed physicien and the burial-transit	cal		d											
687				0.											
Box	eath certifi attending	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of delive	arv	
ă	atte d for	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at]Ectopic p] Other (sp						Month	•	ear
P.0.		Physician/Med	9 Unknown	9⊡ Unknown											
	The law requires that the tie has been signed by thogge 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did t	obacco us	e contribute to the	ne cause of de	ath?
ğ	aure n sig										10	/es 2 ₺	XNo 3 ☐ Prob	ably 4 Dur	ıknown
8	w requires been si	lete									24a. Was	an	24b. Were auto	psy findings av	vailable
Records,	he lav e has	Completed										rmed?	prior to co death?	impletion of car	use of
Vital		Ö	25. Was case referred to medical						26 Place	of Dooth (1 ☐ Yes Check only o	2 No	1 🗆 Yes	2 No	
5	sicie s cert	To B	examiner?	Hospital:	nt 2	ER/Outpatien	t 3 D	Othe					Other (Specif	Uoga t	
ō	Attending Physicien: r death. sctor: After this certifica		27. Manner of Death	28a. Date of Injur (Month, Da)		28b. Time of		28c. Injury Work			d. Describe l			House	
0	th: :: Aft	at le	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	rear)	Injury	м		r Yes 2 □ N	10					
Division of	Atte	=======================================	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At h	ome, farm, str	eet, factor	y, office		28	f. Location (S	Street and	Number or Rura	I Route Numb	Θ <i>Γ</i> ,
ä	To the Hospitef or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	4 - Homeda	building, etc	. (Specii	у)					City or Tov	vn, State)			
	pepit hour iner		29a. Certifier 1 Certifying Phy	sician: To the best	of my kno	wiedge, death	occurred	at the tim	e, date and	place, an	d due to the	cause(s)	and manner as s	tated.	
	n 24 n 24 he Fu	edical	one)	iner: On the basis of and manner sta	examina ited.	ition and/or inv	vestigation	, in my of	oinion, deati	n occurred	at the time,	date and	place, and due to	the cause(s)	
	To t To t	Ž	29b. Signature and title of certifier	1				c. License				_	signed (Month,		
			Michael	Lerne	-	M.D		120	619			Jan	rary ?	7,20	306
1	MILL		30. Name and address of person who c	ompleted cause of d	eath (Iter	п 23а) (Туре,	Print)		. 4						
1	041,		Michael Lerner, M	.D. 63 T	homa	s Johns	son D	rive	, Free	deric	k, MD	2170	2		
	Sta		31. Date filed (Month, Day, Year)	32. Registra			-								
4	Registr	ar	IAN 3 1	2006	A sec	K	12004								

			For State AMEND#7, per Registrar			-	•			ealth a Death	and Mo	ental Hy	giene Reg. No.	006	03995
3	Physicia	an	Decedent's Name (First, Middle									2. Date of De Month	Day		3. Time of Death
7	/Medic	al	ALFRED M. 4a. Fecility Name (If not institution	JACOBS	umher)	_		4b City	Town or	Location o		JANUARY		County of Dea	10:42 A M
	Examin	er	MONTGOMERY GENERAL					OLNE					MON	TGOMERY	
6 -	Funeral		5. Social Security Number	6. Sex	_	(In yrs. la	ast birthday)		r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Bir	nthplace (State or Foreign ountry)
	Director		212-11-6573	1 (ŽM 2 □ F	72	73	Yrs.					1AY 17,			RRA LEONE
	and		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary f sh	tor	MARYLAND MONTGON	ERY		SILVE	ER SPRIN	VG.							1 ☐ Yes 2 Ñ No
	ith the Marylar or 28a-f show	Director	10e. Street and Number					_	p Code				10g. Citiz	zen of What C	ountry?
	23a c		1860 MIDDLEBRIDGE	DRIVE					20906					A LEONE	
	tams	Funeral	11. Marital Status	12. Was De Armed I	orces?			Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Orio n. Mexican	gin? (Spe 1, Puerto F	cify Yes or N Rican, etc.)	0- 1	14. Race - Am Bfack, Whi	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes (2 X No Bive Dates:	0		1 🗆 Yes	2 🛭 No	Specify:				Specify: Bl	LACK
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show int, the Medical Examiner must be moilfied at		15. Deceder	nt's Education			16a. Dece						16b. Kir	nd of Business	s/Industry
215	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+	+)		DO NOT		during most)	t or workin	ig	EMBAS	SY OF	
2	ed wit	Con					DIPLOMA	AΤ					SIERR	A LEONE	
Maryland	be fill	Be	17. Father's Name (First, Middle,	Last)							ers Name	(First, Middle		Sumame)	
2	houid d Mer narks natic	၉	ALBERT M. JACOBS 19a. Informant's Name/Relations	ship (Type Print)			19h Maili	na Addres	s /Street :	AYO	er or Rura		LEWIS	r Town, State,	Zin Code)
M	nd 2 s Ith an 27 is r traur	Ì	MELISSA SASU/DAUGH											ARYLAND	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition			20b. Pl	lace of Dispo	sition (Na	me of	1		ate	,	cation - City o	
Baltimore,	Page ment o ant: if ury or		1 🖾 Burial 2 🗆 Cremation 4 🔲 Donation 5 🗍 Other (S		n State	1	OF HEA				02/04/	2006	SILVE	R SPRING	, MARYLAND
alti	permit. Departmitimporta		21. Signature of Funeral Service	Licensee	,		2:	2. Name a	nd Addres	s of Facilit	HINE	S-RINAL	DI FUN	ERAL HOM	E, INC.
<u> </u>	8358	ii.	Umanda	- Xua	ew	rg					E AVEN	UE, SIL	VER SP	RING, MA	RYLAND 20904
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis fmmediate Cause (Final disease or condition	t only one cause or	each fin.	A						CULAR		EASE	Approximate Interval Between Onset and Death
le:	/Medical		resulting in death)	a. Due t	o (or as a	consequ	uence of):	770		10170	.,,50		,,,,,		
	Examiner		Sequentially list conditions,			FTE.									
-, 5	ed lisit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due t	o (oras a	сопѕеди	ience or):								
	death certificate be executed e attending physicien and id for use as the burial-transit	xau	that initiated events resulting in death) Last	c	o (or as a	consequ	uence of):								
8760,	e be e	calE		d											
9	tificat ng phy as th	Medi							<u> </u>			·		.,	
Вох	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. ff yes, c 1 ☐ Live		of pregna 2 🗌 Fetat	death 3	⊒Ectopic (2	23d. Date of de Month	eliv <i>e</i> ry Day Year
о. П	the dea by the at ached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□ Uni		time of de	eath 5[Other (s	pecify)						
۵.	that the died by the detached		Part II. Other significant condit	ions contributing to	death bu	it not resu	ulting in the u	underlyina	cause div	en in Part I	l.	23e. Did	tobacco u	se contribute	to the cause of death?
Vital Records,		d by	•	5			-	, ,				1	Yes 2	□No 3□F	Probably 4 Unknown
COL	law requires as been sign 2 should be	ompleted								-		24a. Wa	s an	24b. Were a	autopsy findings available ocompletion of cause of
Re	0 - 0	E G										aut per 1 🗀 Yes	opsy formed?	death?	completion of cause of
ta	tician: Th certificete rector, pag	O	25. Was case referred to medical	al	-					26. Place	e of Death	Check only	/ 4	1010	3 2 110
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 XYes 2 □ No	Hospitaf: 1 (Inpatie	nt 2	ER/Outpatie	nt 3 🗆 🗈	OA Oth	er: 4 🗆 Nu	ursing Hor	me 5□Re	sidenc <i>e</i>	6 □Other (Sp	ecify)
0	ding Pt h. After th funeral		27. Manner of Death 1 X Naturaf 5 ☐ Pendi	/8.4	θ of Injur onth, Day	Year)	28b. Time of Injury		28c. Injun Wor		1	28d. Describe	how injur	y occurred	
sio	tendi leath. tor: A the fu	catl	2 Accident invest	igation				М		Yes 2 🗆		206 1	(C4		Decid Control Manager
Division of	at or Attending F s after death. it Director: After ad in by the funera	Certification:		minod 286. Pia	ding, etc	iry - At no :. (Specify	ome, farm, st	reet, facto	ry, office		4	City or T	own, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyi (Check only one)	ng Physicien: To the Examiner: On the and ma	he best of basis of anner sta	examina	wledge, dear tion and/or in	th occurre ivestigation	d at the tir n, in my o	ne, date ar pinion, dea	nd place, a ath occurr	and due to th ed at the time	e cause(s) e, date and	and manner a d place, and du	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifi	er //					c. Licens						nth, Dey, Year)
•			1 John	H)	Mo				DO	030	414	4	JAM	IARV 2	14, 2006
	5		11/	who empleted ca			1 23a) (Type	, Print)	A		۵	_			14, 2006
				RING MO		181	01 1	RINC	e PH	ILIP	UR,	DLA	EY	MARYLA	AND
	Sta Regist		31. Date filed (Month, Day, Year JAN 2	7 2006	Transistra	ar's Signa	H. A	best	1						

			1 - For State Registrar		State	of Maryla		artment of rtificate or			1ental Hy	giene	0.0	000	0.0
4	* 1	- g	Decedent's Name	(First, Middle,	Last)			, imodito o	Dodin		2. Date of De		UD-	3. Time	of Death
	Physici			Simon	Richa	ard I	Kraft				Month Januar	y 23,	2006		9 P. ^M
	/Medic Examin		4a. Facility Name (If I				Mait	4b. City, Town,	or Location	of Death	Januar	<u> </u>	unty of Death	0:2	9 P.
	LAUTIN		Shady Gro		_		1	Rocky							
-	Funeral		5. Social Security Nu		S. Sex		s. last birthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Bir	th	ntgome:		or Foreign
	Director		577-44-239	9	1 ⊠ M 2□ F	7	3 Yrs.	Months Day	s Hours	Min.	July 1	ay, Year)	Cour	rida	or r oronger
E _V	ס		Usual Residence of D	ecedent				l		1	July 1.	J, 1)J	Z TIO	Lua	
	nylan how		10a. State	10b. County		10c. C	City, Town or Lo	ocation					1	Od. Inside	Dity Limits
	a-f s	cto	Maryland	Montgo	mery		Montgo	mery Vil	.lage				\$	1 🗌 Ye	s 2 XNo
	15 th	Directo	10e. Street and Numi	oer				10f. Zip Code				10g. Citizen	of What Cour	try?	
	death with the Maryland rms 23a or 28a-f show		19005 Can	adian (Court			2088	6			IIni	ited St	ates	
	dea	Funeral	11. Marital Status		12. Was De	cedent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or	igin? (Sp	ecify Yes or No	- 14.	Race - Americ	an Indian,	
٥	or its		1 Never Married	d 21K Marrie		2 🔯 No		1 ☐ Yes 212 No			nican, etc.)	1	Black, White,	etc.	
12-003b	within 72 hours after ene. than "natural", or ite ne Madical Exemple	d by	3 Widowed 4	Divorced	Year or	Dates:		TLITES ZELINE	s specify.			Spe	ecify: Whi	te	
ก	72 h natu	Completed	(Specify	5. Decedent's	Education grade completed	d)	16a. Dece	dent's Usual Occi	upation	at of work	ina	16b. Kind o	of Business/Inc	lustry	
V	ithin Nan	idu	Elementary/Second			(1-4or 5+)	life.	DO NOT use retir	ed)		9				
N	e filed within al Hygiene. I other than '	S			5+	•	Mat	hematic	ian			Res	search		
and	tal Hid oth	Be	17. Father's Name (F	irst, Middle, Li	est)				18. Mothe	er's Nam	First, Middle	, Maiden Sur	name)		
y Za	Men Men arke	ုင	C	har1es		Kraft					Belle	Gi1	lers.		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens. Interportant: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Macinal Experimentment is notified a order.		19a. Informant's Nam	ne/Relationshi	o (Type, Print)		19b. Mailir	ng Address (Stree	at and Numbe	er or Rur	al Route Numb	er, City or To	wn, State, Zip	Code)	
2	1 and 3 Health tem 27 other tr		Joan Fede	rico Kı	aft/Wif			Canadia	n Cour	ct,Mo	ntgome	ry Vil	lage,MI	208	386
e	of He		20a. Method of Dispo 1 ☐ Burial 2 🔯				Place of Dispo	sition (Name of matory or other pl	ace)	(Date	20c. Locati	on - City or To	wn, State	
Saltimor	Department of I		4 □ Donation 5					tan Crem		1/25	72006	Alexa	ndria.	Virg	inia
<u> </u>	mit. partr ports y inju		21. Signature of Fund	ral Service Li	censee 1	00		2. Name and Add						0	
מ	885.3		Mu	سعك	DI	تلايكيو	-	East De						208	377
4			23a. Part1. Enter the	disease, or c	omplications that	caused the dea							428, 11	Approxima	ate
П	Physician		Immediate Cause (Fi		nly one cause on	each line.	_							Onset and	
	Physician /Medical		disease or condition resulting in death)		a	170	45/	cit						ENI	MIR
	Examiner			1	D09 t0	o (or as a conse	duence or):				Accepted				
è		ē	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	itions, ediate	b Due to	o (or as a conse	guence of):	woc	ARD)	1110	INI	ARCI	1001	MIN	417-1
	nsit	Examiner	cause. Enter Underly Cause (Disease or in	ing ury	9	,	1								
•	al-tra	xai	resulting in death) La	st	c Due to	o (or as a conse	quence of):								
	ficate be executed physicien and s the burial-transit														
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K	that the death certifit ed by the attending p detached for use as	Physician/Me	IF FEMALE:		23c If yes o	utcome of pregr	ancy								
	atten for u	ian	23b. Was decedent p in the past 12 m	onths?	1 ☐ Live	birth 2 Fet	al death 3	Ectopic pregnance	су			23d.	Date of delive Month	•	Year
5	he d the	ysic	1 ☐ Yes 2 ☐ I 9 ☐ Unknown	No Í	9☐ Unk		dealii 5	Other (specify)						,	
Ľ	that t		Part II. Other significa	ant condition	s contributing to	death but not re	sulting in the ur	aderhina cause a	wan in Part!		23e Did t	obacco uso c	ontribute to th	o sauce of	doath?
Ď.	w requires that s been signed b should be deta	Ω		PETEN.			outing in this ai	roomying dadde g	Trair art a	•		res 2□No			Unknown
5	requ	Completed	////	-10,00								2 110	3 1 100	IDIY 4 E	OTRIOWIT
ט ע	raician: The law s certificate has t lirector, page 2 s	npi									24a. Was autop	an 24	b. Were autop prior to con	sy findings	available
=	ysician: The is certificate hadirector, page	ပ္ပ									perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes		
	cian: ertific ector,	Be	25. Was case referred examiner?	to medical	1		,		26. Place	of Death	Check only o	ne			
-	hysi his c	္ပ	1 ☑ Yes 2 ☑ No		Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA Ot	her: 4 □ Nu	rsing Hor	ne 5 🗆 Resid	dence 6 🗆	Other (Specify)	
=	ding Ph n. After thi tuneral	ä	27. Manner of Death 1 Natural	5 Pending	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time of Injury	28c. Inju	iry at	:	28d. Describe h	now injury occ	curred		
2	tendi leath. tor: A the fu	ati	2 Accident	investigat	ion				Yes 2 🗆 !	No					
Ë	r Att	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	280. Plac	e of Injury - At h	nome, farm, stre	eet, factory, office		1	28f. Location (5 City or Tox	Street and Nu	mber or Rural	Route Nur	nber,
2	ital or ris at lead in lead in	S										,			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours lated death. Within 24 hours lated death. Of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1	Certifying	Physician: To th	e best of my kn	owledge, death	occurred at the trestigation, in my	ime, date and	d place, a	and due to the	cause(s) and	manner as sta	ited.	
	the F the F the F		one)		difficient Ollyma	nner stated.	and/or inv	osugation, in my	ориноп, деа!	ui occurr	ou at the time,	uate and plac	e, and due to	ine cause(3)
	To To Com	Σ	29b. Signature and titl	e of certifier	//				se number			29d. Date sig	ned (Month, E	ay, Year)	
				0		no		00	05-41	139		JANU	ARY	21,	2006
	15		30. Name and address	of person wh	o completed cau	ise of death (Ite	m 23a) (Type, I	Print) 9901	Medic	al C	enter D	r.,Roc	kville	, MD	20850
	10		30. Name and address	2, 6	- Me	1. 1	HAND	- ROVE.	move	NI	11 100	Somo.	-	-	
	Stat Registra	e	31. Date filed (Month,		32.	Dogistrar's Sign	ature	and a							

DHMH 17 Rev 1/2001

Registrar

		For State Registrar		State	of Marylar		artment <i>tificate</i>					giene	16	039	98
Physic		Decedent's Name (I Susan	irst, Middle, Loui	_	Kaibni						2. Date of De Month Januar	Day	Year 2006	3. Time o	
/Med Exam		4a. Facility Name (If no 15500 Riv			ımber)			Town, or mant	Location o	of Death		4c. Count	y of Death tgome	ry	
Funera Directo		5. Social Security Num 225-74-53	93	5. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 60	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 23	y, Year)	9. Birthp Cour New	lace (State ntry) Zeala	or Foreign Ind
Maryland a-f show	tor	Usual Residence of De 10a. State 19	Ob. County	gomery		y, Town or Lo							1	0d. Inside C	City Limits
with the	Directo	10e. Street and Number		7			10f. Zip	Code 0874				10g. Citizen of USA	What Cour	ntry?	
Tar yianid A 14 15-0050 2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or items 23a or 28e-f show aumatic event, the Modical Examinar noist be notified.	by Funeral	15500 Riv 11. Marital Status 1 Never Married 3 Widowed 4 (2 ∑ Marne	12. Was Dec Armed F	2 ⊈No live			ent of His			ecify Yes or No Rican, etc.))- 14. Ra Bla	ce · Americ ack, White, fy: Whi	etc.	
Z I Z I D-UUSO ed within 72 hours aft giene. er then "neturel", or the Medical Exam.	Completed			grade completed	(1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us tive (k done d e retired)	uring mos)			16b. Kind of New Zea Own Hor	aland	-	sy/
Maryiand	To Be C	17. Father's Name (Fin							Ма	vis	Isobel	, Maiden Suma Hender	son		
ESTITIMOTE, MATYIST permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any Injury or other traumatic a	1	Nihad M. I 20a. Method of Dispos 1 □ Burial 2 🖼	Kaibni etion Cremation :	/ Husban	20b. I	15500 Place of Dispo	Rive	er Ro	oad,	Germ Janu	antown Date Lary 26	20c. Location	08 74 - City or To	own, State	nia
Description of the control of the co		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funera 500 University Blvd, W, S													20901
Physiciar /Medica		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Melanoma Due to (or as a consequence of):												Approxima Interval Be Onset and Mont	tween Death
cate be executed physician and the burial-transit	Ical Examiner	Sequentially list cond if any, leading to inin- cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Lass	ing ury	c	o (or as a consec	,									
The Colius, I. C. DOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?	1 Live	utcome of pregn birth 2 Feta gnant at time of one	al death 3	Ectopic pr						ate of deliv	өгу Day	Year
US, T. uires that the signed by the detail	Ď	Part II. Other significa	ant condition	s contributing to	death but not re	sulting in the u	nderlying c	ause give	en in Part	1.	1	tobacco use co Yes 2 □ No		he cause of	
	Completed										24a. Was auto perf 1 Yes		. Were auto prior to co death? 1 Yes	opsy findings impletion of 2 \(\textit{\text{No}}\)	available cause of
Physicien: The this certificate har rial director, page	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatient 2] ER/Outpatie	nt 3 DC	Othe			h Check only me 5 ∑ Aes	one idence 6 □O	ther (Speci	(y)	
of Attending Physics of Attending Physics of Attending Physics of Physics of Attentive Director: After this of the funeral din by the funeral di	Certification: T	2 Accident	5 Pending investiga 6 Could no	ation of be	e of Injury nth, Day Year) ce of Injury - At h	28b. Time o	М		rat ⟨? Yes 2□			how injury occi		al Route Nu	mher
in State				physician: To the	ding, etc. (Speci	owledge, deat	h occurred	at the tim			City or To	wn, State) cause(s) and r	nanner as s	stated.	
To the Hospitel within 24 hours a To the Funeral t completely filled	Medical	(Check only 2 one) 29b. Signature and tit		xaminer: On the and ma	basis of examining stated.	ation and/or in		. License	number	ath occur	red at the time	date and place 29d. Date sign Januar	ed (Month,	Day, Year)	s)
Ò		30. Name and addres				m 23a) (Type, Wisco:		Aven	ue,	#1 3 00), Che	vy Chas	e, MD	2081	5
S Regis	tate trar	31. Date liled (Month,	Day, Year) AN 2	7 2005	Registrar's Sign	ature	parti	,							

			For 1 = State Registrar	State	e of Maryla	and / Depa	artment of	Health a	and Mer		ene ()	6	03999
			Decedent's Name (First, Middle	e, Last)					2.	Date of Death	1		3. Time of Death
c	Physici /Medio		Soon	Nyom		Le	20			Month Inuary	24. 20	Year 06	9:25 a M
Zi.	Examir		4a. Facility Name (If not institution		d number)		4b. City, Town	, or Location			4c. County		
			Randolph Hill:		ng Home		Silver				Mont	gome	ry
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐		rs. last birthday) Yrs.	If Under 1 Year Months Day		Min.	Date of Birth (Month, Day,		9. Birth	place (State or Foreign ntry)
	Director		225 27 9677 Usual Residence of Decedent		87	113.	L		No	v. 26,	1918	Ko	rea
	yland		10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
	e-fs	ctor	Maryland Mont	Omerv	S	ilver S	rine						1 Yes 2000
	or 28	Director	10e. Street and Number	Some y			10f. Zip Code			10	g. Citizen of V	hat Cou	ntry?
	ath w		2005 Tree Top					904				SA	
	Items	Funerai	11. Marital Status	12. Was	Decedent Ever in d Forces? ′es 2∰No	1 U.S. 13. 1	Was Decedent of f Yes, specify Cu	f Hispanic Ori Jban, Mexicar	rigin? (Specify n, Puerto Rica	Yes or No- in, etc.)		e - Ameri k, White,	can Indian, . etc.
36	rs aft	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	If Yes	s, Give or Dates:		1□Yes 2∰N	o Specify:	:		Specify	Asi	an
ğ	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28e-f show ther then "natural", or Items 23a or 28e-f show ont, the Medical Exame must be routified at	ted	15. Deceden	t's Education			dent's Usual Occ			1	6b. Kind of Bu	siness/In	ndustry
215	Ber "n	pie	(Specify only highes Elementary/Secondary (0-12)	<u> </u>	ge (1-4or 5+)	life. I	kind of work don DO NOT use retii	ne during mos red)	st of working				
2	ygien ygien t. The	Completed	12			Homer	naker				Own H	ome	
ind	m = 0 %	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name <i>(Fil</i>	rst, Middle, M	aiden Sumam	θ)	
<u>\</u>	2 should be filed within 72 hours after death with the Maryian and Mental Hygiene. Is marked other then "natural", or Items 23a or 28e-1 show eumatic event, The Medical Examinar must be notified at	2	Yong Joo Lee						ı Lee				
Maryland 21215-0036			19a. Informant's Name/Relations				ng Address (Stree				101		
	i and Health Iom 27		Eun S. Bae / Da	aughter	200	. Place of Dispo	sition (Name of	Ţ	Date Date		oc. Location -		and 20902 own. State
Baltimore,	Pages nent of nrt: If its		1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		rom State	cemetery, cren	natory or other p						
	artme orten injur		21. Signature of Funeral Service	1	M	eadowric 22	Ige Ceme	tery I	1/28/2	2006 E	lkridg	e, M	aryland
B	permit. Depart Import any inj once.		15cmx	a	Lulo								, MD 20904
	_		23a. Part1. Enter the disease, or shock, or heart failure. List	complications th	hat caused the de								Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	_	roke								Onset and Death
.05	/Medical		resulting in death)	a	to (or as a cons	equence of):							4 Years
	Examiner		Sequentially list conditions		oplasm o		ladder						Months
	p tis	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due	e to (or as a cons	equence of):							
	and and -trans	Examiner	that initiated events resulting in death) Last	c.	e to (or as a cons	aguanca of)-							
8760,	pate be executed obysician and the burial-transit		,		5 (O) 23 & CONS	equalica oi).							
687	centificate be executed inding physician and ise as the burial-transit	edicai		d.								7	
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		, outcome of preg						23d. Date	of delive	erv
ň	death e atten	icia	in the past 12 months? 1 Yes 2 No	4□P	ive birth 2 ☐ Fo regnant at time o		Ectopic pregnan Other <i>(specify)</i>	icy			Mon		Day Year
J.	it the de by the a	hys	9 □ Unknown	91.10	nknown								
s,	The law requires that the te has been signed by thoage 2 should be detache	ру Р	Part II. Other significant condition	ons contributing	to death but not r	esulting in the un	nderlying cause g	given in Part I.		23e. Did toba	cco use contri	bute to the	he cause of death?
ord G	w require									1 🗌 Yes	XX No	3 Prob	pably 4 Unknown
ecords,	law ras be	Completed								24a. Was an autopsy	24b. W	ere auto	ppsy findings available impletion of cause of
		Con								performe	ed? d	eath?	2□ No
Vital R	sician; T certificat rector, pa	Be	25. Was case referred to medical examiner?						of Death (Ch				
ō	this al di	2	1 Yes 2 Xo			ER/Outpatien	t 3□ DOA	Nu XX Nu	rrsing Home	5 Residen	ce 6 Othe	r (Specif	y)
0	ding I h. After funer	ertification;	Natural 5 Pendin	g (/	ate of Injury Month, Day Year)		28c. Ing W	ork? □Yes 2□I		Describe now	injury occurre	90	
Division	Attender deatlector:	fica	3 ☐ Suicide 6 ☐ Could r	not be	lace of Injury - At	home, farm, stre				Location (Stre	et and Numbe	r or Rura	ul Route Number,
\equiv	Diriginal Diriginal	erti	4 Homicide	b	uilding, etc. (Spe	cify)			(City or Town,	State)		
	Hospital	Saic	29a. Certifier Certifyin	g Physician: To	the best of my k	nowledge, death	occurred at the	time, date an	nd place, and o	due to the cau	se(s) and mar	ner as s	tated.
	the Hos hin 24 ho the Fun mpletely	edical	(Check only 2 Medical one)	examiner: On the	ne basis of exami manner stated.	nation and/or inv	estigation, in my	opinion, dea	ith occurred at	t the time, dat	e and place, a	nd due to	the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certified	2			29c. Licer	nse number		290	d. Date signed	(Month,	Day, Year)
	3			-			D 00	21033		J	anuary	27,	2006
			30. Name and address of person			/		41	Con-d	. W	1 3 04	2006	
	Sta	to	Byoung K. Lee 31. Date filed (Month, Day, Year)		2 Registrar's Sig	eorgia A		TTAGL	opring	, mary	rand 20	7406	
	Sta Registr		JAN 30	2006	Marco .		well						

			For State Registrar	State of M	aryland /	Departme Certifica			d Mer		iene og. No.	5	0400	0
	Physici		1. Decedent's Name (First, Middle Kenneth	Soonchul	Lee					Date of Deat Month	Day	Year 2006	3. Time of De 6:00P	eath M
	/Medio		4a. Facility Name (If not institution	, give street and number)		4b. City	, Town, or	Location of D		anuar		ounty of Death		
			921 Clopper	Road Apt.	T4			rsburg			Mor	ntgomer	у	_
	Funeral		5. Social Security Number		je (In yrs. last l	Months	er 1 Year Days	If Under 24 I Hours N	vlin.	Date of Birth (Month, Day,	Year)	Cou	place (State or F intry)	-oreign
	Director		586-70-1263	TO IN ZEIT	39	Yrs.			Ap	ril 19	9, 19	966 Ko	rea	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location							10d. Inside City	Limits
	Mary -f sh	ţō	Maryland Mont	gomery	Gait	hersburg	3						1 ¥ Yes 2	! □ No
	r 28a	Directo	10e. Street and Number		.1	10f. Z	ip Code			1	0g. Citize	en of What Co	untry?	
	h with	a D	921 Clopper	Road Apt.	T 4		20	0878		Ur	nited	d State	s of Ame	erica
	dear	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Dec If Yes, sp	edent of Hi	ispanic Origin' n, Mexican, P	? (Specify uerto Rica	Yes or No- an, etc.)	14	Race - Amer Black, White		
98	or it	J. F.	1 ☐ Never Married 2 ☑ Marr	ied 1 ☐ Yes 2 ☐ If Yes, Give		1 🗆 Yes		Specify:			9	Specify: Wh	ite	
21215-0036	72 hours after death with the Maryland Insturel', or items 23s or 28s-f show Lical Expruner rount be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	16	ia. Decedent's Us	ual Occup	ation				d of Business/l		
15	n 72 "nat	iete	15. Deceden (Specify only highes	t grade completed)		(Give kind of w	rork done o	luring most of	working		TOO. Paint	3 01 0031110331	ngostry	
112	within iene. than	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	Busines	ss Ow	ner			Bea	auty_Su	pp1v	
	Hygie other	(a)	17. Father's Name (First, Middle,			Daorie	JU 011	18. Molher's	Name (F	irst, Middle, I			f f = J	
a	Mental Merked o	To B	Hong Suk Le	ee			,	Yor	ng Ra	n Kim				
Maryland	should and Men a marke umatic	Γ.	19a. Informant's Name/Relations	hip (Type, Print)	1:	9b. Mailing Addre	ss (Street a	and Number o	r Rural R	oute Number	, City or	Town, State, Z	ip Code)	
	Health a tem 27 is		Mrs. Yoon Hee	Lee - Wife	9	9634 Bro	okhea	ven Dri		-				
ore	of He		20a. Method of Disposition	3 □Removal from State	ceme	of Disposition (N tery, crematory or	other place	e)	Date		20c. Loc	ation - City or	Fown, State	
Ĕ	Pages ment of ant: If it		4 Donation 5 Other (S		Ft. I	incoln (Jrema	cory 01	1/27/	2006	Bre	entwood	, Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minjoury or other traumatic event, the Macical Examiner must be notified at once.		21. Signature of Funeral Service.	ricensee		22. Name Hines	and Addres	ss of Facility aldi Fi	unera	1 Home	e.In	nc.	ing, MD	200
141	⊈ O E € ol		1-11	n								ver Spr	Approximate	209
The state of the s	Physician /Medical		23a. Pant 1. Enter the disease, or shock of heart failure. List Immediate Cause (Final disease or condition resulting in death)	aChronic	ine.	genous L				spiratory arr	est,		Interval Betwee Onset and De 7 Year	ath
	Examiner	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as	s a consequenc	e of):		× · · · · · · · · · · · · · · · · · · ·			-			
8760,	icate be executed physicien and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as	a consequenc	ee of):								
9	ntifica ing ph a as th	Med	IF FEMALE:					-						
.О. Вох	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		of pregnancy 2 Fetal dea at time of death						23	3d. Date of deli Month	very Day Ye	ear
α.	s that ned b a deta	by Pt	Part II. Other significant condition	ons contributing to death	out not resulting	g in the underlying	cause giv	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of dea	ath?
rds	quire n sig	De De								1 🗆 Y	es 2 🛚	No 3∏Pr	obably 4 Un	nknown
Records,	aw require s been si s should I	Completed								24a. Was a		24b. Were au	topsy findings av	vailable
Re	The la ate ha	EO								perfor	med?	death?	2⊠ No	
Vital	Physician: The lav this certificate has al director, page 2	BeC	25. Was case referred to medica					26. Place of	Death C	Check only or	10)			
† \	Physician: this certificant	To	examiner? 1√2 Yes 2 □ No	Hospital: 1 🔲 Inpat	ent 2 ERV	Outpatient 3 .		4 🗆 1401511	ng Home	5 XResid	ence 6	Other (Spec	cify)	
n of	fter mer		27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	28a. Date of Inj (Month, D.	ury 28t	o. Time of Injury	28c. Injur Wor			I. Describe h	ow injury	occurred		
Sio	Attending Pr r death. ector: After th by the funeral	cati	2 Accident investi	gation		М		Yes 2 □No					10 to 11 = 5	
Division	or Att	Certification:	4 Homicide determ	ined 289. Place of it	ijury - At home, tc. <i>(Specify)</i>	farm, street, fact	ory, office		281.	City or Tow		Number of Hi	ıral Route Numb	er.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Ce		ng Physician: To the bes Examiner: On the basis and manner s	of examination									
	o the	Me	29b. Signature and take of certifie)	A 2	29c. Licens	e number				signed (Mont		
	5 mm		* Edina	JR LONG	00 N	W	DZ	360	1		Janua	ary 25,	2006	
	10	l l	30. Name and address of person Edward Lee	who completed cause of 11065 Litt1	death (Item 23 e Patux	a) (Type, Print) cent Parl	cway,	Colum	nbia,	MD 20	0144			
1	St Regist	ate	31. Date filed (Month, Day, Year)		trar's Signature		2							